Online patient feedback: awareness, usage and attitudes among patients and general practitioners in England

by

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DECLARATION

This thesis is submitted to the University of Warwick in support of my application for the degree of Doctor of Philosophy. It has been composed by myself and has not been submitted in any previous application for any degree.

The work presented (including data generated and data analysis) was carried out by me except in the case outlined below:

- The fieldwork for Study C (i.e. interviewing face-to-face 844 members of the public from across England) was conducted by interviewers from Ipsos MORI.

Parts of this thesis have been published:

Peer-reviewed journal articles:

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Patel S, Cain R, Neailey K, Hooberman L. (2016). Exploring Patients' Views Toward Giving Web-Based Feedback and Ratings to General Practitioners in England: A Qualitative Descriptive Study. *Journal of Medical Internet Research*. 18(8): e217. doi:10.2196/jmir.5865 [Published]

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ABBREVIATIONS

The following are key abbreviations used in this thesis:

Abbreviation	Definition
ATA	Applied Thematic Analysis
BMA	British Medical Association
CAPI	Computer Assisted Personal Interviewing
CCG/s	Clinical Commissioning Group/s
CHC/s	Community Health Council/s
CPPIH	Commission for Patient and Public Involvement in Health
CQC	Care Quality Commission
e.g.	exempli gratia (for example)
FFT	Friends and Family Test
GMC	General Medical Council
GP/s	General practitioner/s
HSCIC	Health and Social Care Information Centre
ICAS	Independent Complaints and Advocacy Service
NHS	National Health Service
NPS	Net Promoter Score
NRS	National Readership Survey
Ofcom	Office of Communications
OPF	Online patient feedback; also used interchangeably with 'feedback on doctor rating websites'
PALs	Patient Advice and Liaison Service
PCT	Primary care trust
PPG/s	Patient participation group/s
PPI	Patient and Public Involvement
PPIF/s	Patient and public involvement forum/s
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners
TSE	Total Survey Error Framework
UK	United Kingdom
USA	United States of America

LENGTH OF THESIS: 79,578 words

ABSTRACT

In the UK's National Health Service, there has been an increasing emphasis on patient and public involvement, formal measures of patient experience, and public reporting of performance measures. This, as well as the emergence of the 'digitally engaged patient', has shifted the traditional paternalistic doctor-patient relationship. There has also been an increase in consumers more generally using rating websites. These factors together led to the formation of online patient feedback (OPF) websites, where patients can choose a healthcare provider based on patient reviews, and give feedback about healthcare providers. Academic research has been conducted on OPF websites, especially to ascertain whether patient ratings online are associated with other measures of quality. However, very little is known about patients' and healthcare professionals' attitudes towards OPF websites.

A multi-phase mixed method design was therefore used in this research to explore patients' and GPs' awareness, usage and attitudes about OPF websites as a mode to give feedback about GPs in England. In Study A, twenty GPs were interviewed to explore their awareness, usage and attitudes towards OPF. The findings highlighted GPs' concerns about OPF, and produced recommendations for OPF website providers. In Study B, eighteen patients were interviewed to explore their awareness, usage, preferences and attitudes towards OPF websites and other methods of feedback available in general practice. The findings from this study helped develop a questionnaire, which was then validated in seven-stages. The questionnaire was then implemented nationally across England in Study C using face-to-face interviews with a nationally representative sample of members of the public (n=844).

The findings from this research produced evidence both for and against OPF websites, suggesting that GPs are highly concerned about the impact of these websites on them, on their professional practice, their reputation and their patients, and are not currently using OPF for improvement. Patient usage and future intention to use OPF websites was also found to be extremely low when compared to other methods of feedback, suggesting that unlike direct methods of feedback, OPF websites currently only appeal to a very small minority of patients. However, there was evidence to suggest that OPF websites fulfil a 'feedback gap' for patients, and unlike other feedback methods, span age, social and regional divides.

The key contribution of this research is that the majority of GPs and patients are not convinced of the value of OPF websites as a mode to leave feedback about GPs in general practice. Rather surprisingly, OPF websites cannot be used currently for patient choice in general practice, nor as a measure of quality, because OPF is biased towards negative experiences, and not representative of patient experience overall. This research provides suggestions on how this could be rectified. However, the NHS should also consider channelling its energies towards providing more direct and private methods of feedback in general practice in England.

CHAPTER 1 - INTRODUCTION

This chapter[1] introduces the research area and presents the rationale or mandate behind this research. This is followed by a description of the scope, aims and objectives of the research. The chapter ends by presenting an outline of the thesis.

1.1 BACKGROUND

Since the 1990s, there has been an exponential increase in the usage of the internet around the world, including a rise in the number of people using the internet for health purposes (Office for National Statistics 2015a). There has also been a growth in the number of people giving ratings and reviews online for products and services (such as on amazon.com), which some argue has allowed for transparent information and communication to influence change, and has provided opportunities for consumers to read reviews and make more informed choices (Filieri 2014; Li et al. 2012; Schuckert et al. 2015).

The National Health Service (NHS) when founded in 1948 was very much paternalistic in its approach to the care of patients (Forster and Gabe 2008). However, from the 1970s onwards, there has been an increasing emphasis on patient and public involvement (PPI) in the NHS, with the introduction of multiple measures to collect patient experience feedback, and the provision of more patient choice (Baggott 2005; Coulter 2011; Forster and Gabe 2008). There has also been a growing emphasis on public reporting of performance measures across the government, including healthcare, and patients are now argued to have a more equal relationship with the NHS and other healthcare providers (Department of Health 2015b; Forster and Gabe 2008).

All of the above factors (reviewed in detail in Chapter 2) led to the evolution of online patient feedback (OPF) websites, with NHS England introducing an OPF website in 2007 – the NHS Choices feedback website (Lagu et al. 2013). 'Online patient feedback' (OPF) or 'feedback on doctor rating websites' (both terms are used interchangeably in this thesis) in the context of this research can be defined as experiential feedback – including both positive and negative comments, ratings,

[1] Parts of this chapter have been published in Patel et al. (2016)

reviews and complaints - left by patients, carers or service users on specially designed public websites (see Figure 1-1 for an example).

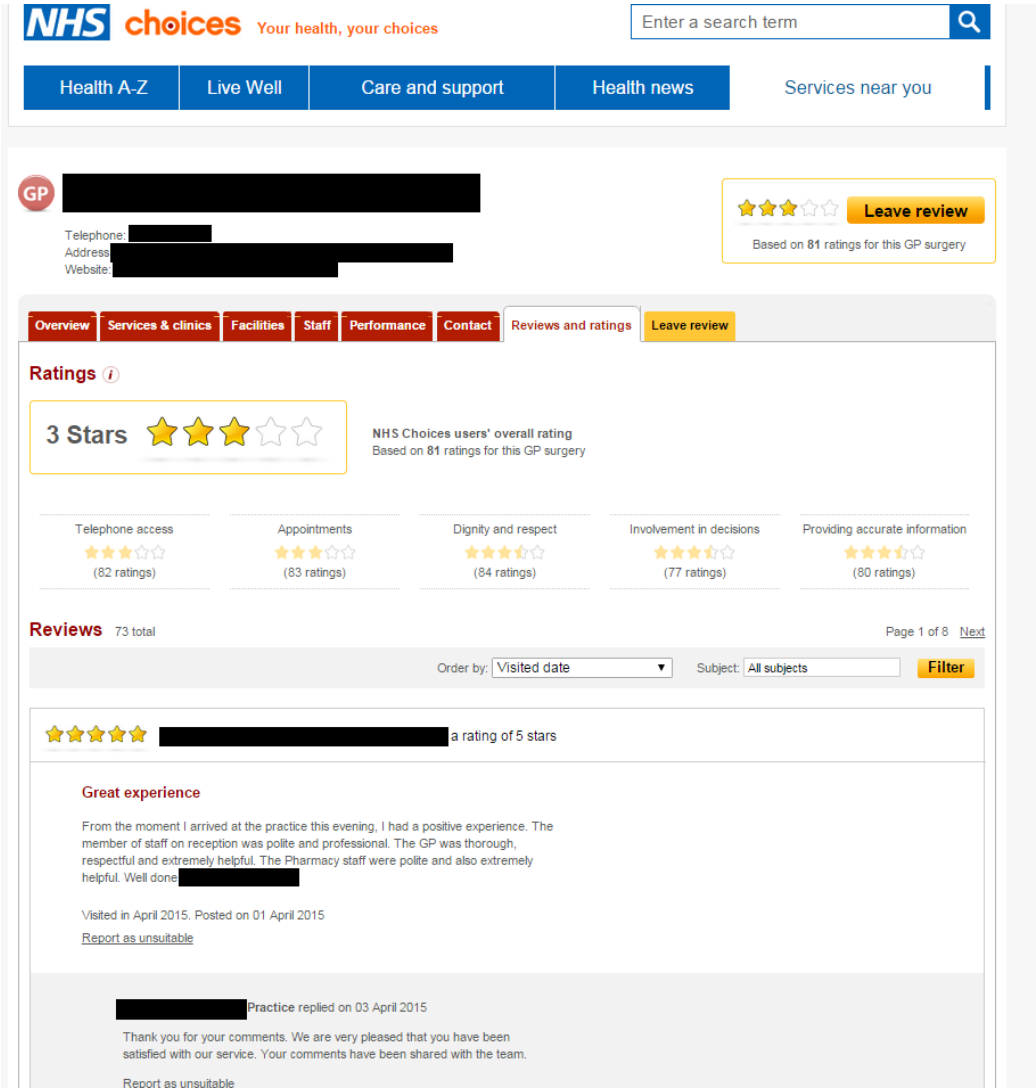


Figure 1-1: Example of OPF on the NHS Choices website (www.nhs.uk)

For primary care and general practice, on OPF websites, patients and carers can i) leave experiential feedback, reviews or ratings under the GP practice's name or the GP's name, and ii) view feedback and ratings left by other patients and carers (NHS Choices 2015). The latter is part of the 'choice' agenda that aims to give patients the tools to choose which GP practice to join (Fotaki 2014; King et al. 2015; Powell 2015). The former, NHS England claims, gives patients a 'voice' to air their feedback and concerns independently in the public domain, intended not only to increase transparency but also bring quality improvement and help empower patients (Greaves et al. 2014c; Lagu et al. 2013; Trigg 2011). However, there is little evidence to date to support this (see Chapter 3).

Nevertheless, there has been a growth in the volume of OPF, which suggests that patients in England (and other parts of the world) are embracing the opportunity to review their healthcare online (Greaves et al. 2012a, 2012b, 2013b; Trigg 2011). There has also been a growth in the development of OPF, with some patients now reviewing not just their experience of receiving healthcare, but also their medication and treatment plan (Hughes and Cohen 2011).

This research was first conceived in 2011, when there were less than a handful of published academic studies conducted in the area of OPF. However, since then, research into OPF websites has increased and is still increasing, with studies conducted in the UK, USA, Germany, Netherlands and Australia all contributing to the OPF evidence basis (see Chapter 3). There is some evidence, not always consistent, to suggest that there is an association between online ratings and the quality of care (Bardach et al. 2012; Gao et al. 2012; Greaves et al. 2012a, 2013b; Segal et al. 2012). In England however, although there was some evidence to support a moderate association between patient experience about primary care narrated online and on conventional patient surveys, the association with clinical quality of primary care was found to be weak (Greaves et al. 2012b).

Studies conducted outside England have explored what type of patients use OPF websites (Bidmon et al. 2014; Emmert and Meier 2013; Emmert et al. 2013a; Hanauer et al. 2014b; Terlutter et al. 2014). However, because the culture about communication and the commercialisation of healthcare is distinctively different in the UK to the USA or Germany, it is difficult to extrapolate lessons from other countries and other OPF websites, and apply them to England (Greaves et al. 2014c). More importantly, the OPF websites are themselves different, because the websites based outside England are predominantly physician-based, whereas the main one in the UK (the NHS Choices websites) is practice-based and is anonymous to GPs (NHS Choices 2015). In the former, patients directly rate and leave feedback for a named GP. In the latter, feedback and ratings for a GP are left under the GP practice's name, and individual GPs are not named in any feedback or review left online.

A few existing pieces of research from England have explored OPF from the patients' perspective (Galizzi et al. 2012; The Tavistock Institute 2011). However, there is very little known about patients' views on OPF websites, such as whether patients perceive any benefits or risks towards giving feedback online, as well as what may motivate or

dissuade them to leave feedback online (Powell et al. 2015). There is also little understanding of how these attitudes, usage and preferences differ from attitudes, usage and preferences towards other feedback methods. Similarly, although a few physician representatives in the media have argued against the introduction of OPF websites (see section 3.3.8), it is not known whether other physicians hold the same views, and whether physicians' attitudes towards OPF websites have changed since 2009.

Understanding how patients perceive and use OPF websites in comparison to other feedback methods can help determine whether OPF websites are of any value to patients, which may potentially help increase usage of OPF websites through improved design and user-experience. Similarly, understanding how physicians perceive OPF websites for gathering patient feedback may help address some of their concerns, identify whether OPF is of any value to them, and whether they would consider using OPF to improve their practice. Furthermore, this can also help determine partly whether the NHS should continue investing in OPF websites.

1.2 RESEARCH SCOPE

This research therefore focused on GPs' and patients' awareness, usage and attitudes towards OPF as a mode to give feedback about GPs in England. The research focused on OPF as a mode to leave feedback only, rather than as a mode for enhancing patient choice. This was done intentionally so that the two purposes would not be conflated. Some of the findings of the research did however contribute to evidence on the use of OPF for choice.

This research focused on GPs and patients in England only. This is because since the devolution of the NHS in 1999, the NHS has been structured, organised and run differently in England, Scotland, Wales and Northern Ireland, resulting in policies being distinctly different, with mainly NHS England placing emphasis on patient choice and competition (Greer and Rowland 2007; Ryan 2016). This may help explain why currently there is no NHS run OPF website in Scotland, Wales or Northern Ireland similar to the NHS Choices website.

GPs were selected as the focus of this research because they are the group of healthcare practitioners with whom most patients first interact, and most regularly

(Goodwin et al. 2011). It could also be argued that patient feedback left for GPs anonymously (under the GP Practice's name) can easily identify the GP in question, especially when the GP practice is very small. This is unlike feedback left by a patient for a hospital, which would normally include details of interactions with multiple healthcare practitioners. GPs are therefore the most 'vulnerable group' because feedback left for them online is most easily identifiable. This may also partially explain why so far, GPs appear to be the most vocal against OPF websites (see Boffey 2011 and McCartney 2009).

General practice has recently come under immense pressure, due to a substantial increase in workload, budget cuts, and difficulties with recruiting and retaining GPs, which led to The Kings' Fund declaring in 2016 that general practice in England is in 'crisis' (Baird et al. 2016). However, general practice is still at the very core of healthcare delivery in the NHS, and a consultation with the GP is the first port of call for the public (Baird et al. 2016; Goodwin et al. 2011). GPs make diagnoses, manage long-term conditions, and refer patients on to specialists and other healthcare or social services (Goodwin et al. 2011). There are approximately 37,000 GPs working in 7,875 practices in England, and each GP on average has 1,577 patients (Baird et al. 2016). Therefore, this is a sizeable population to study.

1.2.1 Research questions and objectives

The research questions and objectives of this research are as follows:

'Are patients and GPs aware of online patient feedback websites as a channel for experiential feedback, and do they use them? What are their attitudes towards them? What are the implications of this for policy and practice?'

Objective 1 – To explore GPs' awareness, usage and attitudes towards online patient feedback websites as a mode for giving feedback about patient experiences of receiving care from GPs (Study A (Phase 1))

Objective 2 – To create and validate a questionnaire to measure patients' awareness, usage and attitudes towards online patient feedback websites as a mode for giving feedback about their experiences of receiving care from GPs (within the context of other feedback mechanisms available in general practice) (Study B (Phase 2) and Phase 3)

Objective 3 – To explore and measure nationally patients' awareness, usage and attitudes towards online patient feedback websites as a mode for giving feedback about their experiences of receiving care from GPs (within the context of other feedback mechanisms available in general practice) (Study C (Phase 4))

Objective 4 – Based on the findings of the studies, to produce recommendations for OPF website providers and GPs/GP Practices, and to inform policy and practice.

1.3 OUTLINE OF THESIS

This thesis contains 10 chapters, as outlined in Figure 1-2.

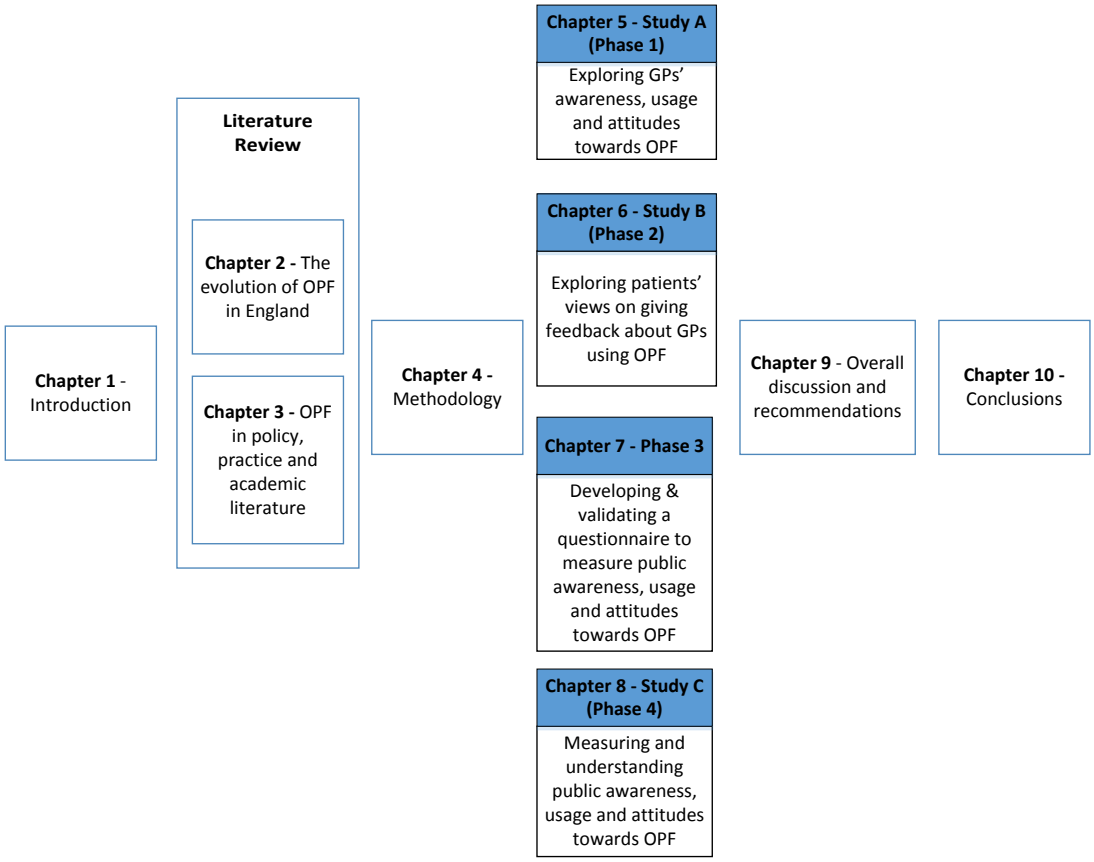


Figure 1-2: Outline of the thesis

Chapter 2: The evolution of OPF in England

After reviewing healthcare policy and academic literature, this chapter discusses the factors that have contributed to the evolution of OPF websites, including the rise of PPI, public reporting of performance measures, the increasing emphasis on measuring patient experience, as well as societal and technological changes. How

patient feedback on experiences with GPs is currently collected in general practice in England is also discussed.

Chapter 3: OPF in policy, practice and academic literature

This chapter starts by reviewing how OPF websites appear in NHS policy, and the characteristics of the different OPF websites in England. This is followed by a detailed review of OPF in academic literature. The chapter ends by identifying the research opportunities, and reiterating the aims and objectives of the research.

Chapter 4: Methodology

This chapter introduces the overall research methodology, and the rationale behind selecting a mixed methods research design. A summary of the methods used for each study is also presented; however, details of the specific methods used for each study are in their respective chapters.

Chapter 5: Study A (Phase 1): Exploring GPs' awareness, usage and attitudes towards OPF

This chapter presents Study A which used qualitative interviews to explore GPs' awareness, usage and attitudes towards OPF. Findings from this study contributed towards: the OPF evidence base produced from this research; the design of the next study; and recommendations for OPF website providers (detailed in Chapter 9).

Chapter 6: Study B (Phase 2): Exploring patients' views on giving feedback about GPs using OPF

This chapter presents Study B which used qualitative interviews to explore patients' views on OPF as a mode to give feedback about GPs. Findings from this study contributed towards the design of the questionnaire in the next phase of the research; and towards the OPF evidence base produced from this research.

Chapter 7: Phase 3: Developing and validating a questionnaire to measure public awareness, usage and attitudes towards OPF

This chapter presents Phase 3 of the research, where a questionnaire to measure public awareness, usage and attitudes towards OPF (as a mode to leave feedback about GPs) was designed and validated. The questionnaire underwent seven stages of validation, and at each stage changes were made to the questionnaire. The validation

stages included public consultation, multiple expert reviews, cognitive interviews and pilot interviews.

Chapter 8: Study C (Phase 4) – Measuring and understanding public awareness, usage and attitudes towards OPF

This chapter presents Study C of the research where the questionnaire from the previous phase was implemented using a cross-sectional design with a representative sample of the public (n=844) in England. Findings from this study contributed towards the new OPF evidence base produced from this research, and produced recommendations for OPF website providers, and GPs and GP practices.

Chapter 9: Overall discussion and recommendations

This chapter brings together and consolidates contrasting and similar findings, and highlights the key new evidence that emerges from the research. The chapter also describes the implications of the research on NHS policy, on OPF practice (recommendations were produced), and on future research. The chapter ends by reflecting on the research approach and process.

Chapter 10: Conclusions

This final chapter provides the key conclusions and contributions of the research.

CHAPTER 2 - THE EVOLUTION OF ONLINE PATIENT FEEDBACK (OPF) IN ENGLAND

The literature review is divided into two chapters. This chapter focuses on the evolution of online patient feedback (OPF), and the next chapter (Chapter 3) focuses on OPF in policy, practice and academic literature.

OPF is a recent phenomenon which emerged primarily from the increasing emphasis in the NHS on patient involvement and feedback, patient choice, public reporting of performance measures, as well as the emergence and popularity of consumer rating websites for services and products. This chapter details the factors that have contributed towards the evolution of OPF (see Figure 2-1 for an outline of the chapter), so that OPF can be understood within the wider context of healthcare policy and practice.

Whilst the demand for patient experience feedback was primarily led by policy changes and highly publicised scandals and failings in the NHS (such as the Mid Staffordshire NHS scandal which led to a public inquiry (Department of Health 2013)), the rise and popularity of rating websites was led primarily by societal and technological changes, with an exponential increase in the number of people using the internet for day to day activities. Both of these areas (policy changes, as well as societal and technological changes) are discussed in detail in this chapter, alongside what patient experience feedback entails and how it is currently measured in general practice.

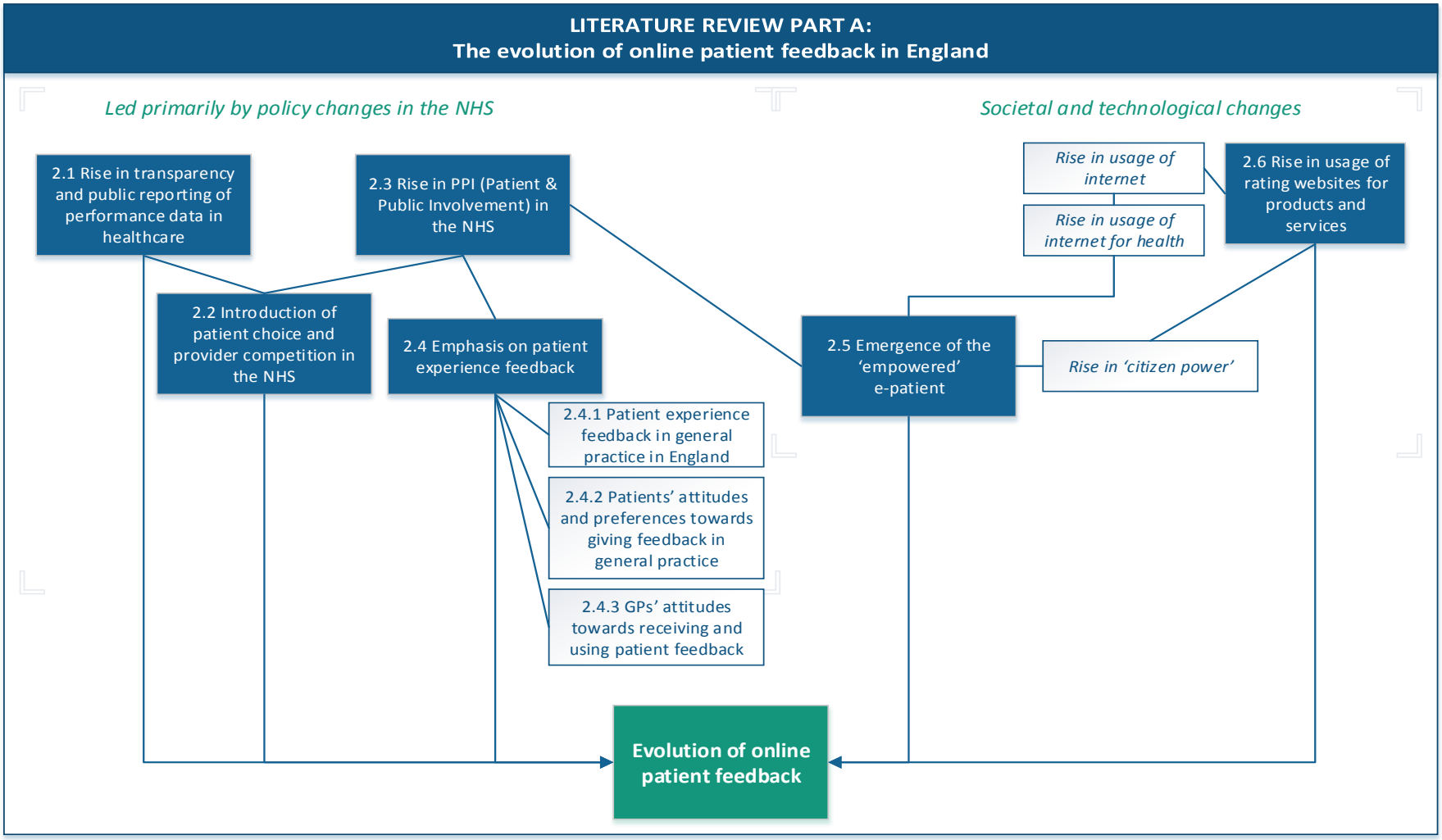


Figure 2-1: An overview of Chapter 2

2.1 RISE IN TRANSPARENCY AND PUBLIC REPORTING OF PERFORMANCE DATA IN HEALTHCARE

Improvement in the quality of care is a high priority for health providers and the NHS, and one of the routine methods for bringing about improvement is to measure performance and publicly report it (Hibbard 2012). Berwick et al. (2003) argue that public reporting may motivate quality improvement in healthcare through two pathways: i) the selection pathway: patients choose the best provider based on performance measures, and therefore concerns about market share motivate provider improvement, and ii) the change pathway: performance measures drive change and improvement. Hibbard et al. (2003) conducted an experimental study with 114 hospitals in the USA and found that making performance information public stimulated quality improvement activity. However, there was no evidence of concerns for market share leading to quality improvement; rather they found that a concern about reputation was the primary motivator for improvement in quality of care. Accountability and monitoring were also mentioned by Robert and Cornwell (2011) as aims of publicly reporting performance measures.

The evidence for publicly reporting performance data to stimulate improvement was found to be mixed in 2000 by Marshall et al. (2000). However, Fung et al. (2008) conducted a systematic review of 45 studies published since 1986, and found evidence to suggest that releasing performance data in the public domain stimulated quality improvement activity at hospital level. Yet there was uncertainty about whether it directly improved quality, and evidence was limited about individual providers and practices. These two reviews together appear to question whether there is some weakness with the theory and/or the way the reporting of performance measures to the public is implemented.

Policy on public reporting of performance data in the NHS in England – Despite the limited evidence in academic literature about the effect of public reporting of performance data on healthcare improvement, the move towards transparency and public reporting can be seen across most sectors of the UK government. Policy changes have meant that much more information is now released to the public (for example, school performance data and crime reports).

In healthcare, this has also been on the agenda, and under the UK Labour government there was a commitment to provide performance data to the public so that patients would have the 'power' to make effective comparisons and exercise choice (Cabinet Office 2008). This led to the launch of the NHS Choices website in 2007 (further details about patient choice are in section 2.2). The coalition government of 2010 also renewed its commitment to transparency and suggested that providing performance data in a useable format to the public will drive improvement (Department of Health 2012b).

The Health and Social Care Information Centre (HSCIC) was therefore set up in April 2013 (renamed as NHS Digital in Aug 2016) as an executive non-departmental public body that provides open data about healthcare. HSCIC argue that open data will improve patient outcomes, increase productivity, contribute to economic growth and increase patient choice (HSCIC 2016b). The NHS Constitution, revised by the Conservative government, also re-iterated the right for patients to have access to comparable data on healthcare quality "to support transparency and drive quality" (Department of Health 2015c).

The Department of Health (2015b) suggested that public reporting of performance data would be implemented by two measures. The first is that from April 2015, all providers who have received a Care Quality Commission (CQC) rating will have to display the rating in all premises (further details about the CQC are in section 2.4.1). The second is the launch of the My NHS website (https://www.nhs.uk/service-search/performance/search), which would provide other performance measures to the public.[2]

It seems that despite the government's commitment to public reporting and transparency of performance measures, recent efforts have been limited to linking external reports which were already in the public domain, instead of integrating these individual results together, and making them easier for the public to understand and use for making more informed choices of providers.

[2] However, the My NHS website is still currently (as of May 2016) in beta. For general practice data, the website provides a link to the NHS Choices website for the GP Patient Survey performance results, and a link to the CQC website for its report (if the GP surgery has been inspected). The GP Patient survey results are also provided on their own website (https://gp-patient.co.uk/), and further details about the GP Patient Survey are in section 2.4.1.

In summary, publicly releasing provider performance data about the quality of care has been argued to lead to improvements through several pathways. The most commonly discussed in health policy is through selection or choice, where patients select their choice based on publicly available provider performance data (including reviews of patient experience on websites), which leads to poor performing providers improving their performance due to concerns about market share (Berwick et al. 2003). Yet the evidence for this appears to be weak, and this will be discussed in detail in the next section. It seems more probable that improvement through releasing provider performance data happens because providers want to protect their reputation (Hibbard et al. 2003). Even though reputation-driven change appears to be missing from policy literature, the notion of rating and leaving feedback online on the NHS Choices website in the UK is driven partly by patient choice and the notion of consumerism (the promotion of consumer interests), and therefore patient choice and provider competition will be discussed in the next section.

2.2 INTRODUCTION OF PATIENT CHOICE AND PROVIDER COMPETITION IN THE NHS

Historically, countries whose healthcare was funded by social insurance (e.g. France and Germany) gave patients the choice to see any specialist doctor, whereas tax payer funded healthcare systems such as the NHS in the UK provided less choice but had better control on costs (Coulter 2011).

In the early 1990s however, the Conservative government introduced market principles (choice and competition) into the NHS (Calnan and Gabe 2001). The idea was that patients would choose providers based on comparative data on the quality of care, and this would promote competition between providers, and be a mechanism for improvement. This is because payment would follow the patient, and therefore it would flow to those providers who are of higher quality and more responsive, and therefore providers would have an incentive to improve the quality of care they provide (Coulter 2011). In short, the idea was that patients' judgement would become the primary mechanism of allocation of resources. However, according to Tuohy (1999), this did not create a choice revolution, because the GP fundholding (internal market) meant that patients were limited to choose from hospitals that had contracts

with their GP (Fotaki 2014, 1999). The choice of general practice (available from 1948) was also constrained by geographical boundaries (Coulter 2011).

Under New Labour after 2002, choice became a major policy goal (Fotaki 2014). Since then, due to legislative reforms, there has been an increase in the amount of choice patients have. Choice was promoted in health policy not only as a mechanism for quality improvement, raising standards and to create a more responsive health system, but also as a mechanism to 'empower' patients (Department of Health 2003). However, Fotaki (2014) argues that patients need better support to make more informed decisions, rather than just being given more options to choose from.

In Dec 2005, choice at the point of referral was introduced, with patients able to choose which local hospital they want to be referred to for specialist treatment and non-urgent surgical operations (Fasolo et al. 2010).[3] Comparative hospital performance data were published on the NHS Choices website, and the Choose and Book system was launched in January 2006 (Green et al. 2008). In 2008, the choice of provider was extended to any hospital in the country, including private hospitals, and this was legally bound as a right in the NHS constitution (Department of Health 2009b). In 2012, under the coalition government, choice was extended to any qualified provider (whether independent, third sector or NHS provider) and to a named-consultant team (NHS England 2013). To extend choice in primary care, the boundary for general practice was removed in January 2015, and patients are now free to register at any GP practice across the country (NHS Choices 2016). The Government's mandate to NHS England for 2020 also promises a significant improvement in patient choice, including for maternity care and end of life care (Department of Health 2016).

There has been considerable criticism of the choice agenda, with critics arguing that evidence for the impact of choice and competition on improvement of clinical outcomes is weak (Dixon et al. 2010; Fotaki 2014), and that in practice patients are not able to choose a provider because they have to go to a local provider due to proximity and access (Calnan and Gabe 2001; Dixon et al. 2010). Others suggested that it may worsen inequity of access because not all groups of patients are able to exercise choice in equal measure (Dixon et al. 2010; Fotaki 2014), and this was also found in a survey commissioned in 2014 by NHS England and Monitor (NHS England

[3] However, patients were unable to choose a specific specialist.

and Monitor 2014). The survey also found that 49% of patients (from 7,038 patients) were not aware of their legal right to choose a hospital or clinic for an outpatient appointment, and less than 40% of patients were offered a choice by their GP when being referred for an outpatient appointment. A study by Green et al. (2008) also found that the Choose and Book system did not deliver on its promise for choice, with 32% of patients (from 104 patients) not being given a choice at all for an outpatient appointment.

Despite this, a survey of 2,181 patients by the Kings' Fund in 2010 found that 75% said that choice was either very important or important to them, suggesting that there was an 'intrinsic value' in giving patients a choice of provider (Dixon et al. 2010). They also found that unlike GP perceptions, those with no qualifications, older respondents and those from non-white backgrounds were more likely to value choice. The same report by Dixon et al. (2010) also found that although patient choice was not driving improvement directly, it was driving it indirectly by presenting itself as a threat to the provider i.e. that the provider might lose patients to another provider. It was therefore motivating them to maintain a good reputation. Furthermore, they also found that providers believed that in the future when choice is well established, it will become a direct driver for improvement, but for now they were relying on other metrics to drive improvement, such as waiting times or infection rates.

The comparative data provided on the NHS Choices website has also come under criticism, with a suggestion that there is too much data (Robert and Cornwell 2011) and patients are not shown data they want (Fasolo et al. 2010; Robert and Cornwell 2011). More critically, the National Patient Choice Survey in 2010 conducted with 69,040 patients in England found that only 6% of respondents (from 69,040 patients) had used the NHS Choices website for choice (Dixon 2010). On a more positive note, the National Patient Choice Survey in 2014 conducted with 7,038 members of the public in England found that amongst those who were offered a choice for their first outpatient appointment (n=1,028), 89% felt they had been given enough information to choose from. It is unknown what role NHS Choices could play in aiding patients' decisions to choose a provider.

In summary, the patient choice agenda has come under considerable scrutiny, with questions about whether it directly drives quality improvement or patient empowerment. However, there does appear to be evidence to suggest that patients

favour being given a choice of provider, and furthermore, the NHS has already invested large sums of money into the patient choice agenda. Dixon et al. (2010) therefore state that although they have not evaluated whether choice is cost effective as a measure, they recommend that policy makers convince GPs of the advantages of patient choice by presenting a cost-benefit analysis. Whether this will be conducted remains to be seen, and is not the focus of this current research.

The NHS Choices feedback website (an OPF website) was created with the 'choice' agenda in mind, and this led to patients being asked to leave ratings and feedback for service providers online, which have typically been displayed alongside quality performance data. Having reviewed the literature around the choice agenda, Dixon et al. (2010) found in 2010 that there appeared to be little appetite for the use of NHS Choices for 'choice'. However, up to date research is required to determine whether this is still the case. It also remains to be seen whether there is demand for the website to be used by patients to leave feedback about their experience of receiving care. Furthermore, questions also need to be raised about what information is being provided by the NHS to non-internet users to make an informed 'choice', as it seems the only tools for patient choice are based online.

2.3 RISE IN PATIENT AND PUBLIC INVOLVEMENT (PPI) IN THE NHS

What is patient and public involvement (PPI)? In many countries, public involvement is now a dominant theme of health policy reforms (Wait and Nolte 2006). The term 'patient and public involvement' (PPI) has been used in British health policy since 1999, and includes a huge spectrum of activity, from service planning, policy making to involvement in research. Forster and Gabe (2008) define it as both individual and collective involvement, at a micro level as patients, at meso level as clients of the NHS, and at a macro level as citizens entitled to healthcare.

Professor Celia Davies distinguishes between patient involvement and public involvement, suggesting that patient involvement means involving patients as service users to give feedback, and public involvement means involving citizens in key decisions, such as in commissioning or policy making (House of Commons Health Committee 2007). In contrast, Foot et al. (2014) suggest that patient or individual involvement is broader than giving feedback, and they describe eight ways that

individuals can be involved in their own healthcare (see Figure 2-2), from evaluating services to shared decision making and taking part in research.

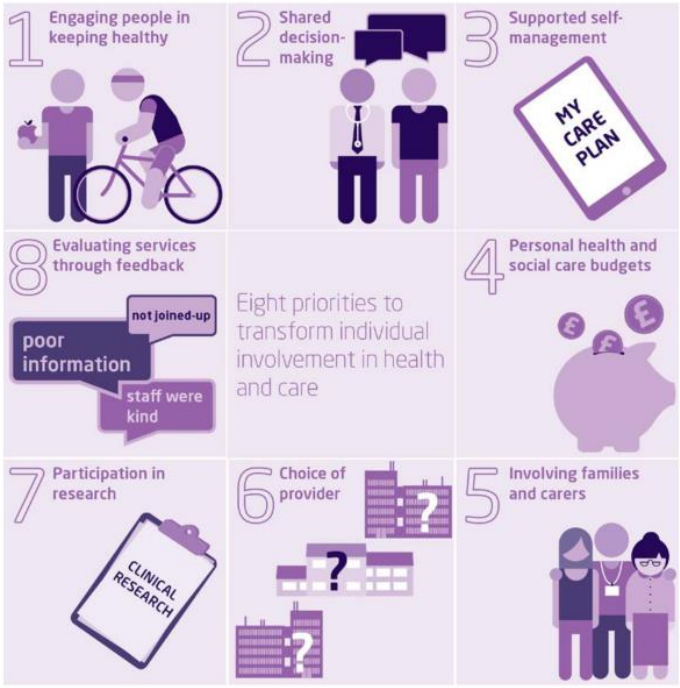


Figure 2-2: Eight ways for individuals to be involved in healthcare.
Source: Foot et al. (2014)

Two approaches or underlying conceptual frameworks to PPI have emerged: democratic and consumerist (Wait and Nolte 2006). The consumerist approach focuses on the need for PPI to record preferences of individual consumers, which can be used to increase market competiveness; whereas the democratic focuses on the need for PPI in order to develop a 'healthy democracy'. The House of Commons Health Committee (2007) described that the main purpose of PPI was to improve the design and provision of services, and to increase accountability.

Current PPI policy in England – Although the NHS was paternalistic in its approach to care of patients when it was founded in 1948, since the creation of Community Health Councils (CHCs) in 1974, PPI has been part of health policy in England, with increasing emphasis and importance attached to PPI (Baggott 2005; Coulter 2011; Forster and Gabe 2008) (a detailed history of PPI policy in England can be found in Appendix A). The coalition government's response to the Mid Staffordshire NHS Foundation Trust Public Inquiry in May 2013 (Department of Health 2013) reinforced putting patients first, and its commitment to fully involve the public in the NHS. It promised a system that was not only more responsive to patient,

staff and public feedback, but one that would actively seek out feedback. It also laid the foundations for the Friends and Family Test (FFT) (further details on FFT are in section 2.4.1).

The NHS England's (2014a) Five Year Forward View report which focused on how the NHS needs to change also assured patients greater control over their own care, with a promise to access their medical and care records, greater increase in choice over where and how they receive care, and an increase in PPI across all sectors of healthcare. After the Conservative Party formed a majority government in May 2015, the NHS constitution was again revised for the second time (Department of Health 2015c). However, there is little evidence as to whether the rights in the NHS constitution are being upheld (Redding 2013).

Levels of PPI in the NHS - The term 'involvement' is a multi-dimensional concept, with levels of involvement varying from giving feedback to co-designing services, and it is often used interchangeably with 'engagement' and 'participation' (Wait and Nolte 2006). Arnstein (1969) developed the citizen ladder of participation (see Figure 2-3), which portrayed the different degrees of interaction, and he suggested that very few levels were real citizen power. In healthcare, the type of involvement can also vary, with individuals being involved in their own treatment care, to public involvement in policy, service design and monitoring service quality (Coulter 2011).

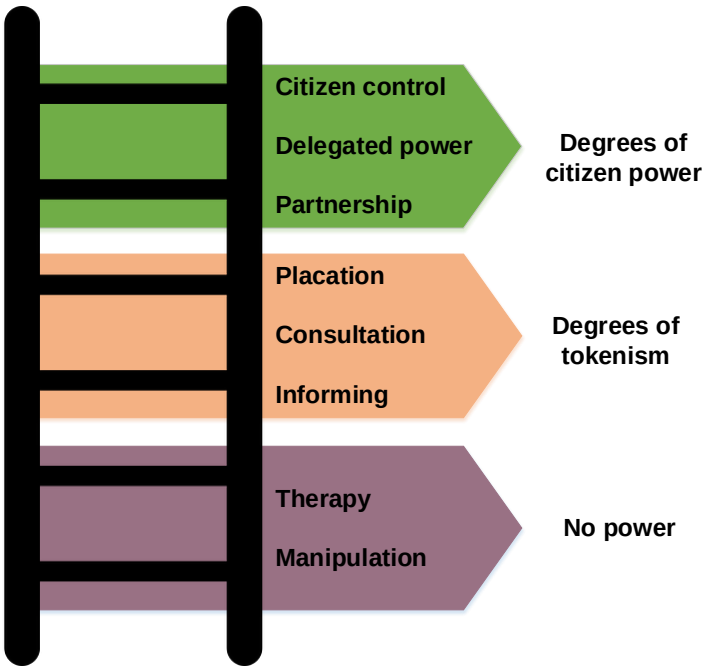


Figure 2-3: Arnstein's Ladder of citizen participation. Adapted from Arnstein (1969).

The NHS Act 2006 (section 242(1B)) highlighted the duty for all NHS organisations to practice good public involvement, and the Department of Health created guidance for NHS organisations on how this could be practiced (Department of Health 2008b). This guidance included an involvement continuum with respective techniques that could be used at each level of involvement (see Table 2-1 for an adapted continuum).

The involvement continuum is similar to Arnstein's (1969) ladder described earlier, and ranges from simply giving information to full-fledged participation, where users are co-designers. The focus of this thesis is on OPF, which is at the second stage of involvement: 'getting information' from patients and carers (see Table 2-1), and specifically relates to gathering patient experience feedback.

Table 2-1: The user involvement continuum and their respective techniques, as suggested in guidance from the Department of Health (2008b)

GIVING INFORMATION	GETTING INFORMATION	FORUMS FOR DEBATE	PARTICIPATION
"We want to tell you what has happened and what we're going to do next"	*"As a user or carer, what was your experience of …?"*	*"Let's try and understand each other's perspective"*	*"How can we work together to find the best solution?"*
Displaying information Media Public meetings	**Requested and spontaneous views *(patient experience feedback)*** Citizens' panels Focus groups Surveys/e-surveys Shadowing Artwork, photography and other creative means Mystery shopper Open surgeries/ conversation cafés	Discussion groups Health panels Nominal group technique	Co-design/ co-production 21st Century town meeting Citizens' juries User groups Story telling/ patient diaries Participatory appraisal Forum theatre World café

2.4 EMPHASIS ON PATIENT EXPERIENCE FEEDBACK IN THE NHS

What is patient experience? Patient experience can be understood as what the patient experiences when receiving care, and also how the experience made them feel (National Quality Board 2015). It can include lived experiences, responsiveness of services, communication, information, support and continuity of care and relationships (Staniszewska et al. 2014).

A good patient experience is an integral part of providing high quality healthcare, and in the NHS, a good patient experience is one of the key three aspects of high quality care, alongside patient safety and clinical effectiveness (NHS England 2014a).

Systematic literature reviews conducted by Doyle et al. (2013) and Price et al. (2014) provide evidence that patient experience is positively associated with clinical effectiveness and patient safety, and therefore they argue that patient experience is an integral part of quality in healthcare, and can help improve clinical and safety outcomes.

According to Raleigh and Frosini (2012), the quality of care provided to patients by GPs is measured typically in two ways: i) the Quality and Outcomes Framework (QOF) – which measures whether GP practices meet the threshold across agreed clinical indicators, and they are rewarded if they do – and ii) the patient experience of using a GP service, usually measured by patient surveys. More recently, the latter category of patient experience has now also been included in the QOF (HSCIC 2016a).

Current policy on patient experience feedback – The revised NHS Constitution in 2015 (Department of Health 2015c) reiterated the responsibility of the patient to leave both positive and negative feedback about their experiences to help improve NHS services. It added that patients can often provide feedback anonymously and encouraged carers to leave feedback on the patient's behalf. The guidance published alongside the constitution (Department of Health 2015b) illustrated that feedback in the NHS could be left through national, local or practice surveys or real-time feedback systems, or through the Local Healthwatch.

The NHS complaints guidance (Department of Health 2015a) was more specific and outlined that there are two ways for patients to tell the NHS what they think; either by giving feedback (through the FFT or by speaking to a staff member) or by complaining to either the healthcare provider (for example the GP surgery or hospital) or the commissioner (the organisation that paid for the service or care). If a patient needs support with making a complaint they are encouraged to contact either the local council, local Healthwatch or Patient Advice and Liaison Service (PALs). If the patient is still not happy with the response provided, they can ask the independent Parliamentary and Health Service Ombudsman to look at the complaint.

The multiple aims of collecting patient experience feedback – For a long time, the NHS has promoted patient experience feedback as a means for driving improvement and standards (Newbould et al. 2015). Based on a review of academic

literature, Russell (2013) suggested that ten purposes of collecting patient feedback could be found in the literature (all listed in Table 2-2). Amongst them is the aim to change professional practice. However, Russell (2013) also indicated the many individual, organisational and systemic barriers that can be identified in the literature, that prevent feedback from changing professional practice.

Patient experience can also be used as an evaluation tool to measure which services are appropriate and provide value for money (National Quality Board 2015), and make the healthcare system more in tune with patients' needs and expectations (Contandriopoulos et al. 2014; Roberts et al. 2014). Furthermore, it can be used to increase accountability to commissioning boards, trusts, the government and patients (Robert and Cornwell 2011). Robert and Cornwell (2011) argue that measuring patient experience can also increase transparency if shared in the public domain, while Jabbal (2016) states that patient experience can be used by regulators for quality assurance, performance assessment, and by patients for informed choice.

Table 2-2: Aims of collecting patient experience feedback.
Adapted from a literature review conducted by Russell (2013)

Aims of collecting patient experience feedback	Supporting source
1. Provide information	(Kalucy et al. 2009)
2. Measure quality of healthcare services	(Raleigh and Frosini 2012)
3. Improve quality of healthcare	(Evans et al. 2007)
4. Change professional practice	(Ivers et al. 2012)
5. Evaluate innovations	(De Leon et al. 2012)
6. Improve the quality of specific interventions	(Hancock et al. 2012)
7. Measure coordination of care	(Robert and Cornwell 2011)
8. Compare health services	(Fung et al. 2008)
9. Rate healthcare services	(O'Dowd 2012)
10. Improve compliance	(Browne et al. 2010)

Although policy initiatives in the NHS have strongly advocated the collection of patient feedback, the question really is whether patient feedback has led to improvement. Coulter et al. (2014) argues that there is not enough evidence to suggest patient feedback is being used, with clinicians ignoring the data, or mistrusting it (see section 2.4.3 for a discussion on GPs' attitudes towards patient feedback). However, a systematic review of literature on the association between patient experiences and other measures of healthcare quality found that patient experience measures, as long as they are implemented correctly, are 'intrinsically meaningful', and complement other clinical and outcome measures (Price et al. 2014).

Despite this, results of multiple surveys with over 140,000 NHS staff found that 41% of them had not received patient experience training, and 22% believed it did not apply to them (Robert et al. 2014). The authors recommended that patient experience be incorporated into NHS staff training.

Methods to collect patient feedback in the NHS - Patient experience feedback can be measured in a variety of ways (see Figure 2-4) and guidelines for measuring feedback have been provided by the NHS (see NHS Institute for Innovation and Improvement 2009); and in academic literature (see Brown et al. 2009; Edwards et al. 2015; Silva 2013). There does however appear to be a consensus that there is no one perfect method for gathering patient experience feedback, with each method having strengths and weaknesses (Brown et al. 2009; Coulter et al. 2014; Entwistle et al. 2003). This is why Entwistle et al. (2003) argue that healthcare providers should offer a range of complimentary feedback methods, so that all patients have the opportunity to give their views, and providers can use patient views to improve the quality of care and services.

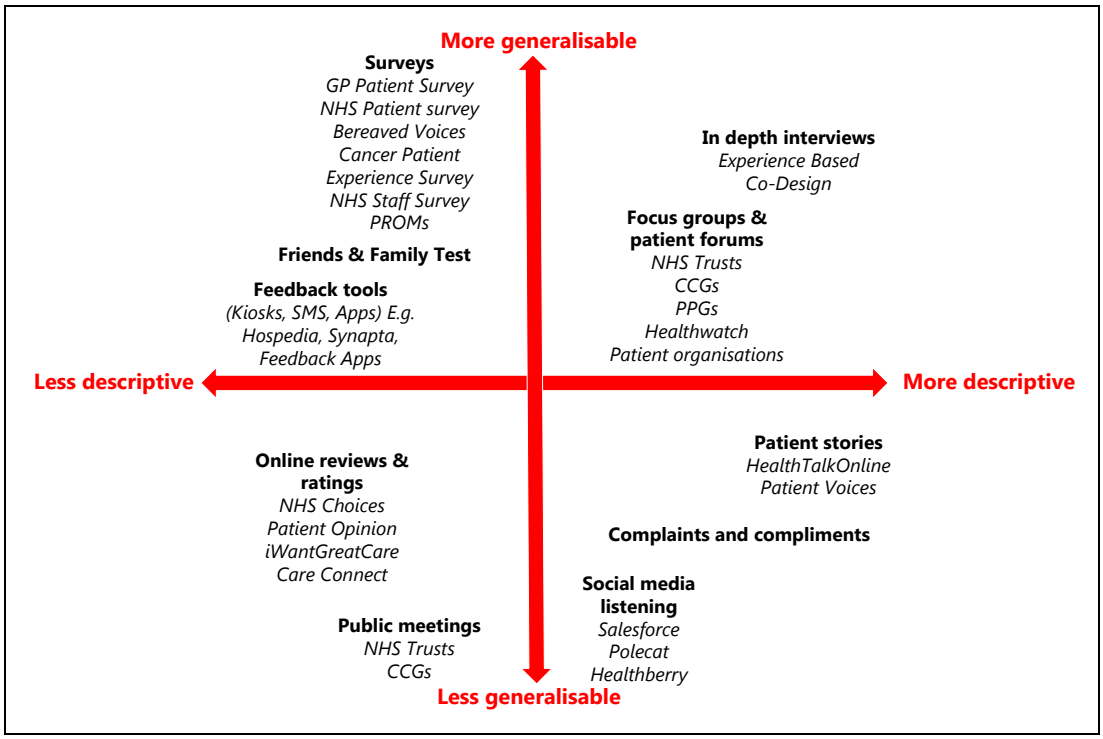


Figure 2-4: Matrix of methods that could be used to measure patient and carer experiences of health services in the NHS.
Adapted from Silva (2013) and Wellings (2016).

2.4.1 Patient experience feedback in general practice in England

In general practice in England, there are a multitude of ways in which patients' views and experiences can be captured (Gillam and Newbould 2016), both in terms of the type of feedback that is captured and the means by which it is gathered (Wensing and Elwyn 2003). The most popular methods to currently collect patient feedback in general practice are the Friends and Family Test (FFT), GP Patient Survey, and feedback collected through patient participation groups (PPGs). Other methods of giving feedback such as OPF websites are available to all NHS users who are online, although it is unclear how well they are promoted by GP practices (further details about OPF is in Chapter 3). Table 2-3 illustrates the methods that patients and carers can currently use (in 2016) to give feedback in general practice, and their key characteristics.

Table 2-3: Sources of capturing patient feedback in general practice in England in 2016, and characteristics of each method
(The list of methods was adapted from Gillam and Newbould (2016))

Method	Is the method available to all patients?	Is it mandatory for the practice/GP to implement?	Is the response from GP/practice in the public domain?	Can the practice/GP respond to the patient that left the feedback?
Friends and Family Test (FFT)	✓	✓	✓	×
GP Patient Survey	×	✓	✓	×
In-house surveys and suggestions boxes	*At the discretion of the practice*	×	*At the discretion of the practice*	*At the discretion of the practice*
Surveys for re-validation	×	✓	×	✓
Patient participation groups	✓	✓	×	✓
Care Quality Commission (CQC) ratings	×	✓	✓	×
Complaints procedure	✓	✓	×	✓
Online patient feedback (OPF) websites	✓	×	✓	✓
Social media and Insight dashboard	✓	×	✓	✓

Friends and Family Test - The Friends and Family Test (FFT) was launched in 2013, and it is a single question measure or intervention based on the Net Promoter Score (NPS) (The NPS is used widely by retail companies, as well as in other industries, see

Grisaffe 2007). The single question quantifies the response asked to patients: "How likely are you to recommend our service to friends and family if they need similar care or treatment?" It has a scale ranging from extremely likely to extremely unlikely, and is followed by a brief optional comment from the patient explaining the reason for their score (NHS England 2016b, 2014c). It can be implemented in any way the practice prefers, such as paper-based questionnaires, digital tools or text messages (Coulter 2016).

FFT has now been launched in most NHS funded services in England (NHS England 2016b), and GPs are under contractual obligation to implement FFT in general practice (NHS England 2014b). NHS England (2013) argues that the FFT test is advantageous because it is close to 'real-time' feedback – therefore service providers can make changes based on it very quickly – and it is open to all patients to leave feedback. It appears that many patients are taking up the opportunity to leave feedback using FFT (Powell et al. 2015), with 10 million responses recorded in two years (NHS England 2016a), and by May 2016, over 20 million (NHS England 2016c).

However, the FFT has also come under considerable scrutiny, and criticism has mainly been around three issues: the mode of questioning, the way the FFT is administered, and the way the data is used (Picker Institute Europe 2014). Critics argue that a single response to a question will not identify the reasons behind the response, more critically what changes are needed to improve the service, and furthermore patients may find it difficult to summarise their entire experience into a response to a single question (Davis and Panagiotopoulou 2014; Picker Institute Europe 2014). Despite this, Hamilton et al. (2014) found that over a 5 year period, 96.5% of their 6,186 patients undergoing limb joint replacement at a large university hospital in England responded to the FFT question in their satisfaction questionnaire.

There were also concerns about the difficulties that patients may encounter when interpreting the FFT results presented on the NHS Choices website (Davis and Panagiotopoulou 2014). NHS England (2014c) has since promised to present the results in a clearer and more understandable format. Coulter (2016) also criticised FFT and questioned their reliability and validity because of the lack of control over sampling procedures and the inability to calculate a response rate. Furthermore, a recent study by Dutch academics found that the NPS score was less valid as a measure of patient experience than existing measures used in the Netherlands (Krol

et al. 2015). However, researchers in the UK found, after prospectively assessing 6186 patients, that although the Net Promoter Score (NPS) (used in FFT) was different to satisfaction responses, it did measure patient experience of receiving care, which other metrics did not measure (Hamilton et al. 2014).

Despite the criticism, the Government's mandate to NHS England for 2020 is to increase the number of people using the FFT to recommend services, and use it alongside other sources of feedback for service improvement (Department of Health 2016). There is however little known about how 'visible' FFT is in practices and clinics. The same could be asked about other methods, including OPF websites.

GP Patient Survey - In general practice in England, patient experience feedback has been traditionally collected primarily through patient surveys (Goodwin et al. 2011). The GP Patient Survey is an annual national postal survey, first introduced in 2006, to measure patient experience of healthcare services in general practice, including access, quality of care and satisfaction. It is sent on behalf of NHS England to randomly selected patients from all GP practices in England, and patients respond anonymously (NHS England 2016d). The results of the survey are published on the GP Patient Survey website (https://gp-patient.co.uk/).

The results of the GP patient survey were also included in the quality and outcomes framework (QOF) from 2009 to 2011, and during this period, GP practices were given financial incentives when patient experience quality indicators were achieved (HSCIC 2016a). Policy initiatives such as these suggest that measuring patient experience data through surveys will improve the quality of care provided to patients. However, there is an increasing amount of evidence to suggest that patient experience survey data is not being used effectively in general practice to bring change or improvement (Asprey et al. 2013; Barry et al. 2015; Boiko et al. 2014; Coulter et al. 2014; Edwards et al. 2015) (further details about GP attitudes towards patient survey data can be found in section 2.4.3).

In-house surveys and suggestions boxes – In-house surveys developed by the practice or adapted from other questionnaires are available in some practices (Gillam and Newbould 2016). Some practices may also have suggestion boxes. However, there are no requirements from the NHS for practices to provide either of these methods to

collect feedback from patients, and they are under no obligation to make the responses to these surveys public.

Surveys for re-validation – As part of the re-validation process for GPs, since December 2012, GPs are required to gather patient feedback as well as colleague feedback for re-validation (GMC 2016). The General Medical Council (GMC) provides a template questionnaire that GPs can use, and GPs are advised to seek a minimum of 34 patient responses (GMC 2016). The responses to the questionnaire are not made public.

Patient participation groups – In 1972, the first patient participation groups (PPGs) were established in general practice under the Royal College of General Practitioners (RCGP), with an aim to be the voice for patients and be involved in the improvement of services (Box 2009). The remit of PPGs is wide and the volunteer patients' roles can vary from collecting patient feedback to involvement in research, commissioning and improving services (Box 2009; Gillam and Newbould 2016; Nagraj 2011; Newbould et al. 2015) .

Despite policy initiatives encouraging PPGs, the uptake was slow, and by the early 1990s there were only an estimated 300 PPG groups. However in 2011, there was an exponential increase in the number of PPGs because the government financially incentivised setting up 'patient reference groups' (although optional) in the GP contract (Gillam and Newbould 2016; NHS Employers 2011). This meant that by 2013, two thirds of all practices had a PPG (Withers 2013). The enhanced service payment for PPGs was stopped in April 2015.

Despite little mention of PPGs in recent policy documents from the government (Gillam and Newbould 2016), the requirement remains in the contractual agreement for a practice to provide a PPG (NAPP 2016; NHS Employers 2014). The CQC also places importance on collecting feedback from PPGs during an inspection (Newbould et al. 2015).

However, there is no mandate from NHS England on how a PPG should be run (and there has never been) and there is no obligation to record the activities of the group (Gillam and Newbould 2016; NHS Employers 2014). PPGs have freedom as to how they are organised and what activities they are involved in (Box 2009), and this Nagraj (2011) argues makes it not only difficult to assess their impact, but also to

establish and sustain them. They have also come under criticism for being unrepresentative (Gillam and Newbould 2016), while members of the group have complained that their voices are not heard (Newbould et al. 2015). Gillam and Newbould (2016) suggest this is because the aims of PPGs are not well defined, there is limited training or resources, and there are no incentives.

Despite this, Gillam and Newbould (2016) still argue that although there are a wide range of sources from which patient feedback is collected, PPGs are unique because of their long term presence and intimate nature, which they suggest means that feedback given through PPGs is more likely to be used for improvement, and also a two-way conservation with the patient is easier to establish.

It seems that although PPGs have their limitations, and have not been mentioned in recent policy documents, it is unlikely they will be abolished in general practice due to them being well established since 1972. There is little evidence so far on how useful or effective they are in collecting patient feedback and ensuring that feedback is used for improvement purposes.

Care Quality Commission ratings – The Care Quality Commission (CQC) was established in April 2009 as an independent new health and social care regulator to ensure that the NHS provides patients with high-quality safe care (National Quality Board 2015). Since the commencement of their new approach to inspection in October 2014, they have inspected 45% of all GP practices in England (CQC 2016a). While inspecting a practice, they collect patient feedback to help make their assessment. The results of the inspection are published on their website (CQC 2016b). They do not collect patient feedback about GPs or practices outside of their inspection remit (CQC 2016b).

In January 2016, the CQC came under criticism from the British Medical Association (BMA) who called for a reform to the body. A survey by the BMA GPs Committee with 1900 GPs found that 90% of GP practices believed that CQC's inspection ratings were 'too simplistic or misleading' to accurately measure quality of care (BMA 2016a).

Complaints procedures – All general practices in England are under contractual obligation to have a complaints procedure in place for patients to complain, and the CQC, when inspecting a practice could ask the practice about how complaints are being dealt with, and how they are being used to improve services and the quality of

care (BMA 2016b). There is no requirement however to share complaints with NHS England. Practices must send an acknowledgement of receipt to the patient within three days, and are encouraged to address the complaint as soon as possible (BMA 2016b).

The NHS complaints guidance (Department of Health 2015a) outlines that if patients are not happy with the practice's response, they can complain directly to the commissioner (NHS England). If the patient is still not happy with the response provided, they can ask the independent Parliamentary and Health Service Ombudsman to look at the complaint. If a patient needs support with making a complaint, they are encouraged to contact either the local council, local Healthwatch or PALs.

Online patient feedback (OPF) websites – Patients are able to leave feedback and rate their experience of care received in general practice on websites such as NHS Choices and iwantgreatcare.org. As OPF is the focus of this thesis, it will be discussed in detail in Chapter 3.

Social media and Insight dashboard – Social media, such as Facebook and Twitter could be used by patients to leave feedback about their experience of healthcare. NHS England is currently (as of May 2016) trailing a new social media and insight dashboard (in beta: http://insightdashboard-dev.appspot.com/). It was described in the *Transforming participation in health and care* report by NHS England (2013) as a dashboard that would collect patient feedback from social media platforms, and present them in a way that could be easily understood by the public and the local Healthwatch.

The report also emphasised the importance of harnessing patient feedback from social media, and describes it as an "emerging, fast growing and important source of insight" (NHS England 2013). Greaves et al. (2013a) also argued in 2013 that harnessing already existing data on social media could inexpensively provide new insights into the quality and safety of care. However, Greaves et al. (2014b) conducted a study in 2014 analysing tweets directed at hospitals in England and found that there was no association between sentiments on twitter and other formal measures of quality. They suggested that policy makers need to re-evaluate whether statements on social media can really be used as a way of monitoring quality of care. Furthermore, it

is still not clear whether most GP practices and hospitals have a social media presence, and whether they are using social media to harness patient feedback.

However, CareConnect, a multi-channel feedback website was piloted by the NHS (see section 3.2.2) between 2013-2015 which gave patients the opportunity to leave feedback using Twitter and Facebook (Shah 2015). The researcher monitored tweets on Twitter sent to @careconnectNHS and found that although the service ran for over a year, there were no tweets to them from the public giving feedback or complaining about a GP.

In summary, social media is available to all internet users to comment or complain about their experience of receiving care if they wish to do so. There is evidence to suggest that the public are discussing health issues on Twitter (Antheunis et al. 2013; Lupton 2016), and this is also demonstrated by the Healthcare Hashtag Project[4] operated by Symplur (2016), and the successful #hellomynameis campaign run by patients in the UK on Twitter (O'Dowd 2016b). However, there is little evidence to date to establish whether patients are using social media to leave feedback about their experience of general practice in England.

2.4.2 Patients' preferences and attitudes towards giving feedback in general practice

In 2001, the Department of Health commissioned an independent national evaluation of the complaints procedure in the NHS, and found that many of the complainants were highly dissatisfied with the complaints procedure, especially due to the attitude of staff when a complaint was raised, and poor communication (Posnett et al. 2001). Similarly, Entwistle et al. (2003) conducted a population survey with 1951 Scottish NHS patients and found that many patients were reluctant to give negative feedback about their care to healthcare providers, and what they called a significant minority (around 5% for inpatient care and 1% for GP care) would not use any method to give feedback, because they did not believe the provider would be responsive. Litva et al. (2002) also conducted eight focus groups and interviews in England and found that although the public were eager to be involved in system and programme-level

[4] This website analyses twitter data related to healthcare, and produces a database of relevant hashtags that people can follow, with an aim to connect people in healthcare more efficiently.

decisions, they were reluctant to be involved in patient-level decisions, such as which of two patients should get a novel treatment.

Coulter et al. (2014) and Entwistle et al. (2003) both argue that there is no one perfect method for collecting patient feedback, and the study by Entwistle et al. (2003) also appears to support that. Entwistle et al.'s study (with 1951 Scottish patients) also asked respondents who they would raise concerns with about poor care from a GP, and found that: 49.2% said they would talk to another GP in the practice; 28.8% said they would talk to the same GP again; 13.2% said they would contact a patient representative; 3.7% said they would contact the practice manager; 1.2% said they would telephone a NHS comments line; 0.9% said they would use a NHS feedback website; and 0.2% said they would fill in a NHS feedback form. This suggests that the majority of Scottish patients prefer to raise concerns about poor care from a GP, with GPs themselves.

However, this study was conducted 13 years ago, and the NHS feedback website was not available then to use, but was rather suggested as an idea to patients. Furthermore, this hypothetical feedback website was described to patients as a private website where patients could submit feedback that would then be passed on to the relevant healthcare provider, with no suggestion that the feedback would be left in the public domain (as OPF websites currently are). Furthermore, internet usage and attitudes towards the internet have changed since 2003. Therefore, patient attitudes towards the NHS feedback website and other OPF websites, as well as patients' most preferred method to leave feedback still needs to be determined.

Having said that, the same study by Entwistle et al. (2003) also reported the reasons why patients chose one method of feedback over another. This included the perceived ease of use, likelihood of being heard, feedback being used for improvement and how that could help others, as well as the uptake of staff time and resources. These factors although found in 2003, may still be useful to evaluate any new methods of feedback introduced in the NHS. It would also be beneficial to explore whether these reasons for preference of one feedback method over another still stand.

2.4.3 GPs' attitudes towards receiving and using patient feedback

Although the NHS places great emphasis on GPs using patient feedback to improve care and services (as discussed earlier in section 2.4), recent studies exploring the attitudes of GPs towards patient survey feedback paints a different picture.

Boiko et al. (2014) conducted focus groups with staff from 14 English general practices to explore their views on patient feedback obtained from surveys. They found that staff acknowledged the usefulness of feedback but questioned the survey's validity and reliability, both in terms of the way it is implemented and the actual questions asked. Asprey et al. (2013) also conducted interviews with practice staff (including GPs) in 10 general practices and found that GPs questioned the credibility of the GP Patient Survey results, believing that the results were not representative for example, or that the response rate was too low. A report funded by the Department of Health (Carter et al. 2009) also mentioned that some GPs were concerned that patients may not be able to accurately recall their experience weeks or months later.

Studies also suggest that GPs are facing difficulties using or understanding the survey data. Boiko et al. (2014) for example found that using the survey feedback data only, staff found it challenging to implement changes. In a study conducted by Asprey et al. (2013), GPs felt that survey data did not give enough detail to take action towards improvement, while GPs in South Wales suggested that patient experience surveys were difficult to interpret because it was not clear whether the feedback was aimed at an individual GP or the practice as a whole, and also whether it was directed towards the GP as a person or towards his or her professional behaviour (Edwards et al. 2011). GPs in the latter study also did not feel confident about using the feedback to make changes.

Barriers to using the results of patient surveys have been identified in the literature and, as mentioned earlier, these can be individual, organisational and systemic (Russell 2013). A systematic review conducted by Miller and Archer (2010) concluded that there was limited evidence that multisource feedback would lead to an improvement in performance of doctors. In contrast, a Cochrane systematic review conducted by Ivers et al. (2012) established that feedback does lead to minor yet vital changes to professional practice. However, this really depends on who is being surveyed and how the results are then presented back to the professionals. They

suggested that further studies are needed to compare the effectiveness of different feedback methods.

Edwards et al. (2011) on the other hand suggest that clarification is required as to who the results of the patient survey are targeted towards and for which purpose, while Boiko et al. (2014) suggest more guidance is needed from the NHS on how staff in primary care (including GPs) can make effective use of patient survey data to bring improvement.

It is important to note that that in all of the aforementioned studies, GPs did acknowledge the positive aspects of patient feedback, although they were sceptical overall about the value of patient survey data. In the study by Asprey et al. (2013), GPs were found to have positive attitudes towards feedback, and GPs in Edwards et al.'s study (2011) believed patient feedback was 'highly important'. GPs in Boiko et al.'s study (2014) acknowledged the usefulness of feedback and recognised that survey feedback could be therapeutic to patients as patients will feel their voice is being heard, and it could also be used for improvement and for re-validation of GPs.

In summary, the aforementioned studies show that that GPs' attitudes towards patient feedback are positive, however they have concerns about the credibility of patient surveys. GPs have difficulty in making sense of the survey data and are not using patient survey feedback currently for improvement, because the data as it currently stands and is presented does not appear to be fit for use.

Studies could not be found in the literature that explored GPs' attitudes towards other feedback methods, such as feedback from OPF websites or the FFT. However, interestingly, a recent large qualitative study with over 10,000 doctors in the UK found that the complaints procedure has had a detrimental impact on doctors' wellbeing, and makes them practice more defensively (Bourne et al. 2016). The doctors proposed that complaints procedures need to be "simplified, time-limited and more transparent".

2.5 EMERGENCE OF THE 'EMPOWERED' E-PATIENT

The rise in the use of internet for health - There has been an increase in the usage of internet around the world, and in the UK, 87.9% of adults were found to have used the internet in the past 3 months (Office for National Statistics 2016). Furthermore,

86% of households now have access to the internet, with 78% of households accessing it every day (Office for National Statistics 2015a). Similarly, there has been an increase in the number of people using the internet for health purposes. In 2015, the Opinions and Lifestyle Survey found that 49% of the population in the UK had used the internet to look for health related information, in comparison to just 18% in 2007 (Office for National Statistics 2015a).

This suggests that the internet is becoming an increasingly popular source of health information for patients, with patients able to connect to each other and share experiences using social media, blogs, chats, forums, wikis, and on specially designed online health communities such as PatientsLikeMe (van der Eijk et al. 2013; Lupton 2013). Lupton (2013) argues that patients are using technology to become experts of their own healthcare, and are being encouraged to use technology to monitor their own care.

Policy changes in the NHS to 'empower' patients – A shift in policy in the NHS to 'empower' patients was discussed briefly in section 2.3 under PPI. The *NHS Plan 2000* under the new Labour government provided this major shift, and Forster and Gabe (2008) explain that the plan used four strategies to 'empower' patients. Firstly, better information about health services and treatments was promised, including the introduction of patient choice. Secondly, shared decision making was introduced in an effort for patients to be treated as 'partners'; however little guidance was given on how this could be implemented. Thirdly, the *Patient Charter* was revised to resemble a contract between the NHS and its clients, with views being sought from surveys that would be standardised, nationalised, integrated into hospital performance ratings and publicised, as well as the establishment of the PALs and the Independent Complaints and Advocacy Service (ICAS). Fourthly, patients were encouraged to self-manage their own health, and this led to the creation of *The Expert Patient* in 2011, which although was innovative, its effectiveness to improve healthcare outcomes has been questioned (Forster and Gabe 2008).

More recent government policy also prioritised patient empowerment, with the promise of "no decision about me, without me" across health policies (McAllister et al. 2012; NHS England 2013) and in the NHS constitution (Department of Health 2015b).

Emergence of the 'empowered' or digitally engaged e-patient – Both of these factors – changes in policy and the increasing use of internet for health – alongside an increasing emphasis on democracy and citizen power appear to be leading to a transformative cultural shift from traditionally passive patients to 'empowered' e-patients, where patients and healthcare professionals are seen as equally involved in decision making processes, and patients self-manage their illnesses.

Lupton (2013) describes this as the emergence of the 'digitally engaged' rather than 'empowered' patient. This appears to be further supported by a recent CQC report (based on an analysis of multiple sources, including national patient survey data) which found that there has been no improvement in patient involvement in the NHS in the past 5 years, with a significant minority of people consistently reporting that they do not feel involved or only to some extent in their own healthcare (Care Quality Commission 2016). Therefore, while there is not enough evidence to suggest that e-patients are truly empowered, there is evidence to describe them as 'digitally engaged'; using digital media to become more informed about their own healthcare and sharing that knowledge with other patients too (van der Eijk et al. 2013; Lupton 2013).

2.6 RISE IN USAGE OF RATING WEBSITES FOR PRODUCTS AND SERVICES

In the past decade, due to the advancement of internet technologies, there has been an exponential increase in e-commerce and online consumer reviews (Schuckert et al. 2015; Zhang et al. 2014). Consumers can leave their views and evaluations of a product or a service on either rating websites or other digital media platforms like blogs, forums, e-commerce platforms and social media. Other consumers then use these reviews and ratings in their decision-making for purchase.

Retailers are also harnessing online consumer reviews as a marketing tool, and some are encouraging consumers to evaluate products and services online (Floyd et al. 2014). For example, Amazon.com had 35 million reviews on its website by March 2013 (Leskovec 2016), and their reviews appear to be so popular that under their Vine programme, they give free products to selected customers to review (Amazon 2016).

Another well-known consumer review website is TripAdvisor.com, which allows travellers to read and review hotels and travel sites. The reviews and ratings together

produce a ranking list of hotels or travel sites within an area. The website has millions of global visitors daily, and according to Jeacle and Carter (2011), independent travellers place an increasing amount of trust in the reviews on Trip Advisor.

There has been considerable focus in academic literature on online consumer reviews, and Lee and Youn (2009) suggest that studies either focus on the market level (to determine whether reviews can affect sales and revenues) or on the individual level (to determine whether online reviews affect consumers' decision making). For the market level, two recent meta-analyses have confirmed the strong impact of online consumer reviews on sales (Babić et al. 2015; Floyd et al. 2014). On an individual level, Cheung and Thadani (2012) conducted a literature analysis, and produced an integrative framework of the impact of online consumer reviews, outlining that there were several crucial dependent factors, including the adoption of online reviews, product attitude and purchase intention.

The expectation when reviews are in the public domain would be that reviews would drive significant behaviour changes in the service provider in order to control their reputation. For example, negative reviews on Trip Advisor can be very damaging to the hotel, so one would expect the hotel to make changes based on the reviews. A study conducted by Cunningham et al. (2010) between 2007 and 2009 using Trip Advisor reviews found that an increased awareness of Trip Advisor among hotel managers in the Irish hotel sector led to improvement in quality. However, in the same period, a similar level of improvement could not be found in Las Vegas hotels, and this they suggest is because a huge number of reviews were already prevalent for Las Vegas on Trip Advisor. Whether a similar type of behavioural pattern can be found in healthcare and OPF still needs to be determined.

Nevertheless, there are multiple surveys, mainly at industry level that suggest that consumers are increasingly using and giving online reviews for products and services (for example PwC Global (2016) and Euromonitor (2013)). A survey of 2674 UK residents by Ofcom (2014) found that 44% of adults in the UK use consumer reviews. Furthermore, 56% of people who buy things online say they often read user reviews, but only 11% often write them. It is yet to be determined whether a similar discrepancy between using online reviews and writing reviews can also be found in healthcare.

The growth in online consumer reviews and electronic communication had appeared to reach such epic acceptance and usage levels that an app called 'Peeple' was proposed in 2015 to rate and review any person (Kleinman 2016). However, the app raised criticism and backlash from the public, and it was therefore amended and re-launched in Canada and USA in March 2016. The updated app gave those who are rated full control over which reviews go on their profile page, and the star rating system was also removed (Kleinman 2016). The backlash from the public hinted towards strong negative public attitudes towards personal rating systems being in the public domain. Research is still needed to determine whether the public have the same negative attitude towards online ratings systems about healthcare professionals, and also how healthcare professionals perceive such personal ratings and reviews of themselves being online in the public domain. Knowing this could help determine whether OPF websites are of some value to patients and healthcare professionals.

In summary, there is no doubt that the proliferation of online consumer reviews has transformed the lifestyle of internet users, many of whom are unable to book a hotel or make a large purchase without having consulted consumers' reviews first. Whether a similar type of need is found in healthcare remains to be determined, and this will be discussed in further detail in Chapter 3.

2.7 SUMMARY

This chapter reviewed the different factors and policies that led to the evolution of OPF websites (or doctor rating websites), providing the context and overview of the field in which OPF sits. The review suggests that PPI, patient choice, public reporting of performance measures, as well as societal and technological changes (with the increase in use of the internet, online consumer review websites and the emergence of the e-patient) all appear to have contributed to some extent towards the introduction of OPF websites. OPF may also be a drive towards an increase in transparency, improvement, choice and patient empowerment. The next chapter will explore whether there is any evidence in the academic literature to suggest that this is true. The chapter will also review OPF websites in NHS policy and practice, and establish the research needs and the research question.

CHAPTER 3 - ONLINE PATIENT FEEDBACK (OPF) IN POLICY, PRACTICE AND ACADEMIC LITERATURE

This chapter reviews online patient feedback (OPF). The first half of the chapter reviews how OPF appears in health policy in England, followed by an analysis and explanation of the different OPF websites in England. The second half presents a review of OPF in academic literature, and concludes by establishing the research question and objectives.

3.1 OPF IN NHS POLICY

The NHS Policy on gathering patient experience feedback was discussed in Chapter 2. This section reviews NHS policy specifically in relation to OPF.

The NHS first introduced an OPF website - the NHS Choices website (www.nhs.uk) - in 2007 (NHS Choices 2010). From the beginning, users had the opportunity to comment on their hospital experience, and in 2009 patients were also able to comment on their primary care experience. In early policy documents, the emphasis of the NHS Choices website appeared to be more on patient choice, rather than collecting patient experience feedback (see Department of Health 2008a).

Similarly, NHS Choices was introduced in the media as a Trip Advisor style website (Smith 2009), with the then Health Minister Ben Bradshaw famously commenting: "I would never think of going on holiday without cross-referencing at least two guide books and Trip Advisor. We need to do something for the modern generation in healthcare" (Carvel 2008). Despite the BMA's GP committee criticising such an approach and describing it as 'irresponsible' (Carvel 2008), the *NHS 2010-2015* five year plan proposed in 2009 by Andy Burnham reiterated that the NHS will continue to expand the range of patient feedback available on the NHS Choices website (Department of Health 2009a).

In early 2012, the NHS Future Forum recommended that the Government set out a clear way forward on how patient generated comments through all forms of social media can be recognised and used to improve services (NHS Future Forum 2012). The government accepted the recommendation and promised to set out a way forward, whilst commenting: "feedback, comments and complaints, via all forms of social

media, have the potential to offer valuable insight into people's experience of health and care services" (Lansley 2012). Yet to date, NHS trusts and organisations are under no obligation to respond to or use the comments left by patients on NHS Choices or on social media; and little is known about how and if the comments are being used for improvement or for choice by patients.

A discussion paper by The NHS Confederation (2012) warned NHS organisations that formulaic responses to patient feedback, both online and offline, can harm their reputation. Furthermore, they envisaged that as the volume of stories through social media will rise, skilled frontline staff may enter online conversations with patients directly, instead of PALs or the director of communications responding to the feedback. They also argued that the transparency of OPF can become a driver of cultural change and change organisational and professional behaviour (The NHS Confederation 2012). However, there is little evidence to date to suggest this is happening.

In July 2013, Tim Kelsey, the National Director for Patients and Information at NHS England announced that in response to the Mid Staffordshire crisis, a new 'Trip-Advisor' for patients will be introduced in the NHS, so that patient and carer experiences are transparent, and could be used to improve healthcare outcomes (Kelsey 2013). In September 2013, the *Transforming participation in health and care* guide for commissioners from NHS England (2013) named the website as CareConnect, and recommended that to improve patient experience, feedback should be collected using a range of methods (see Chapter 2), including online feedback websites such as CareConnect and Patient Opinion, as well as complaints, social media and the Friends and Family Test (FFT) (there was no mention of the NHS Choices website). Although CareConnect was piloted between July 2013 and February 2014, it was abolished in 2015 (McBeth 2015) (further details about CareConnect are in section 3.2.2). The difference between the NHS Choices feedback website and CareConnect was that CareConnect's focus was solely on collecting patient feedback (and not patient choice), whereas NHS Choices catered for both choice and feedback.

Interestingly, since 2013, there has been no mention of OPF in NHS policy documents, such as the Handbook to the NHS Constitution (Department of Health 2015b), although FFT and the Local Healthwatch are mentioned under the right of patients to leave feedback. The NHS complaints guidance (Department of Health

2015a) also mentioned the FFT and local council as channels to leave feedback, and the local Healthwatch and PALs for advice on giving complaints, but there was no mention of OPF websites. This is an interesting development, especially considering that the NHS Choices feedback website is still live (as of writing this – Aug 2016), and the NHS very recently invested heavily in creating a new OPF website (CareConnect), despite it being very similar to an already existing independent OPF website called Patient Opinion. The different OPF websites available in England are discussed in the next section.

3.2 OPF WEBSITES IN ENGLAND

3.2.1 Users and providers of OPF websites

The stakeholders of OPF include both providers and users (see Figure 3-1). Patients are both providers of OPF (when leaving feedback) and users of OPF (when choosing a healthcare provider). Similarly, NHS England is also a provider of OPF (because it provides an OPF website called NHS Choices) and is a potential user of OPF (because they can use the website to monitor healthcare providers). Other stakeholders such as Clinical Commissioning Groups (CCGs) may also have an interest in OPF, because they could also use the feedback to audit and monitor healthcare providers. However, there is little known about how and to what extent any of these stakeholders (including patients) are using OPF, and for which purposes.

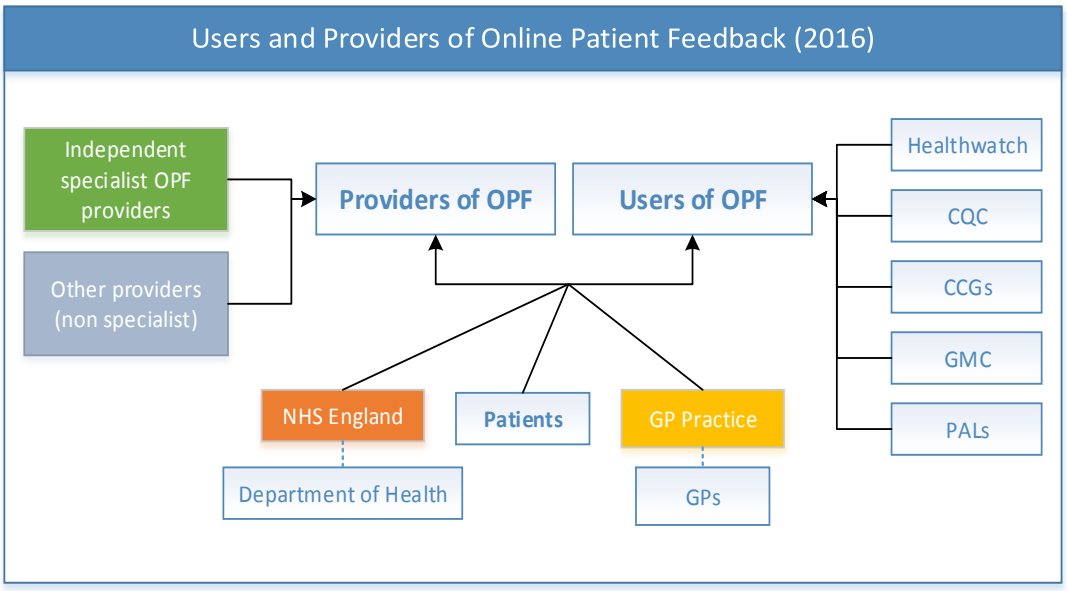


Figure 3-1: Stakeholders of OPF in England (as of Aug 2016).

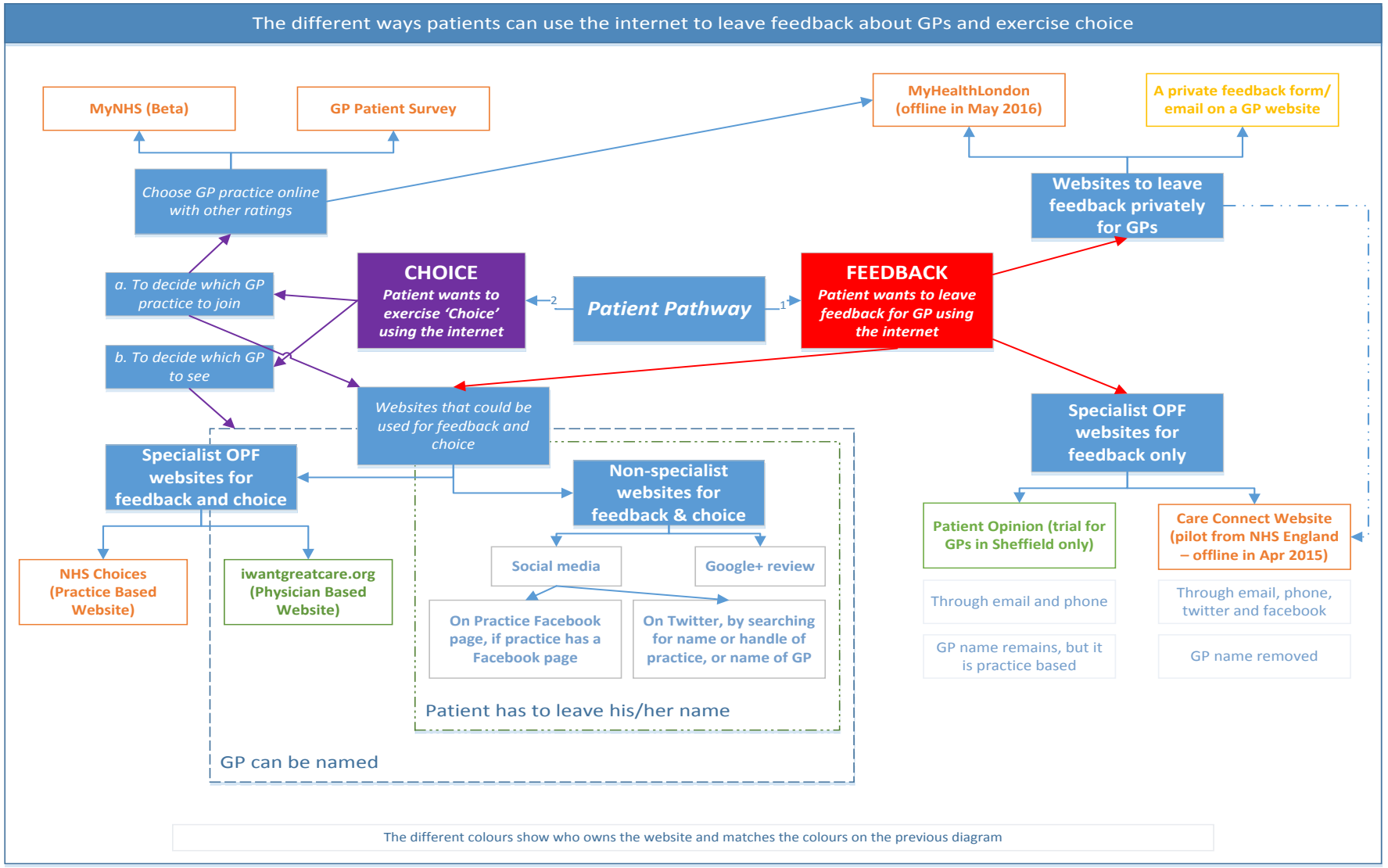


Figure 3-2: The different ways patients can use the internet to leave feedback about GPs and exercise choice (as of Aug 2016)

3.2.2 Different websites for patient feedback about GPs

If a patient in England would like to leave feedback about his or her GP using a website, there are different ways they could do this (see Figure 3-2).

Specialist OPF websites – There are two types of specialist OPF websites in England: i) allows patients to leave feedback, and also use patient feedback to make a choice of provider, with the design of the website suggesting a greater emphasis on choice; and ii) designed to elicit feedback only (and not for the patient to use the feedback for choice). The latter type of website allows the patient to track changes made using their feedback in real-time.

(i) **Specialist OPF websites for feedback and choice (but cannot track changes nor multi-channel)** – There are two major websites in the UK that are specifically designed for patients to leave feedback for health service providers and use the feedback to decide which provider to see (both are live as of Aug 2016):

a. **NHS Choices feedback website (a practice-based OPF website)** (http://www.nhs.uk/Pages/HomePage.aspx) – This government run website started in 2007. It allows patients to choose a provider based on patient feedback and encourages patients to leave feedback for health services run by the NHS, in England (NHS Choices 2010). Studies have analysed the content of the patient feedback left on this website too (see section 3.3).

Since 2009, this website allowed patients to leave feedback about their GP under the name of the GP practice where the GP works and it can therefore be categorised as a practice-based OPF website. The website also removes the name of the GP if mentioned in a piece of feedback, and all comments are moderated before they are posted online (NHS Choices 2015). Patients can leave feedback anonymously on this website and are encouraged to do so (NHS Choices 2015). It is however unknown whether patients want to leave feedback anonymously; and whether they want to leave feedback that is anonymous to GPs or other healthcare professionals (and this is explored in Studies B and C of this research).

Based on the name and the design of the website, it could be argued that this website's emphasis is more on patient choice rather than collecting feedback (although feedback is needed for patient choice). However, it is unknown how many patients are currently using this website to leave feedback or to exercise choice.

b. **iwantgreatcare.org website (mainly a physician-based OPF website)** (https://www.iwantgreatcare.org/) – This independently run website started in 2008 and allows NHS and private healthcare patients to rate individual GPs and other healthcare practitioners about the care they have received in the UK. The website is much closer in design to the doctor rating websites found in the USA and Germany, because it requires patients to name and rate individual GPs.

In April 2015, it also allowed patients to rate the GP practice as a whole. The website only allows patients to leave feedback for those GPs and GP practices that have registered on the website. Patients can also search for the name of the GP or healthcare practitioner and read reviews left for them, and can also leave feedback anonymously if they wish to do so (IWantGreatCare 2016).

In 2012, this website also had an Apple based app for their feedback services, but it was not active in April 2015. It is unknown how much feedback is left on this website; how many patients are using this website to exercise choice or to leave feedback for healthcare providers; and why the feedback app became inactive.

(ii) **Specialist OPF websites for feedback only (can track changes and multi-channel)** – There are two websites in England that allow patients to leave feedback in public, and the design of the websites suggests that the feedback cannot be easily used for choice of provider. However, they do allow the patient to follow the changes made with their feedback in real-time:

a. **Patient Opinion** (https://www.patientopinion.org.uk/) – Patient Opinion was launched across England in 2006, and was originally partly funded by the Department of Health (Patient Opinion 2015b). It is an independent organisation that collects feedback for health services across the UK, and in April 2015, it ran a trial for collecting feedback for GPs in Sheffield. The service to collect feedback for GPs has not yet been launched across England.

   The website is unique in that it focuses on improvement or action, based on patient feedback. It does this by displaying a number of features for each patient comment submitted on its website: whether the feedback has been listened to; whether there has been a response; and whether a change has been made as a result of the feedback.

b. **CareConnect** (https://www.nhs.uk/careconnect/choices) – This website was launched in July 2013 by NHS England as a pilot service for London and parts of the North East of England, and it ran until February 2014 (Kelsey 2013; McBeth 2015). Like Patient Opinion, it showed the public in real-time what changes were being made as a result of the feedback left on this website (see Figure 3-3). Despite spending £1.25M to create the website, plans to launch it across England were scrapped (McBeth 2015), and the website was offline in April 2015.

   The only major difference between Patient Opinion and CareConnect was that CareConnect also allowed patients to leave feedback through text message, through twitter (@careconnectNHS) and via their Facebook page (the Twitter and Facebook accounts were deleted by April 2015). However, 381 tweets mentioning @careconnectNHS (between the period of Aug 2013 - Jan 2015) were analysed by the researcher in April 2015, and found that although the service ran for over a year, there were no tweets from the public giving feedback or complaining about a GP, which may suggest that patients may not be likely to leave feedback about GPs on social media. However, more evidence is needed to support this.

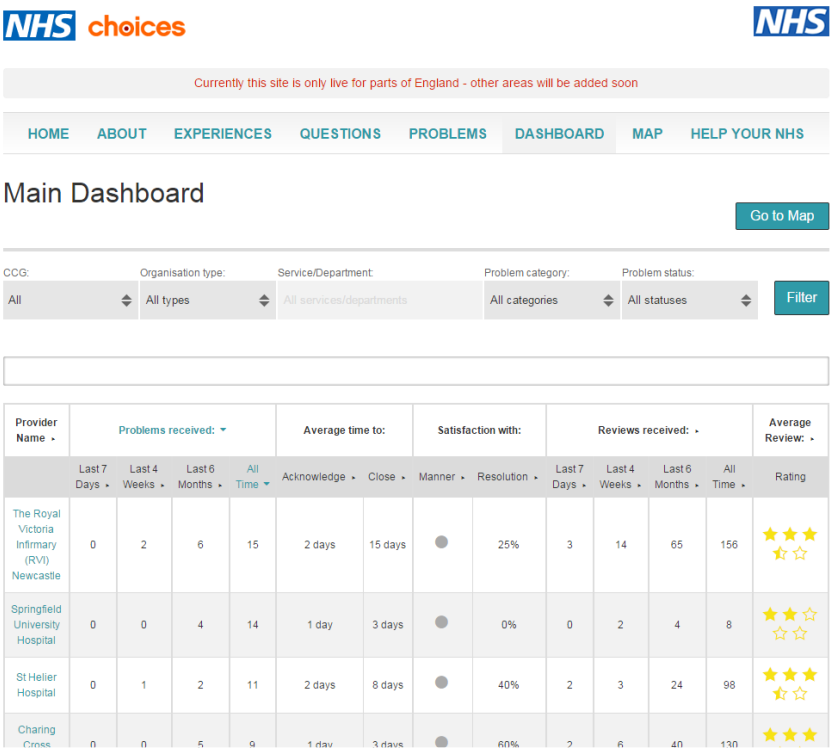


Figure 3-3: A screenshot of the archived real-time dashboard of the CareConnect website (offline by April 2015)

Non-specialist websites for feedback and choice – Patients could leave unsolicited feedback for their GP on social media websites, such as Facebook, by either leaving a comment on the GP practice's page, on the GP's personal page (when their profile is public) or on any of the other NHS pages (such as the NHS trust page or the PALs' page). Similarly, patients also appear to be leaving feedback on Twitter, and in particular for hospitals, as Greaves et al. (2014a) found. It is still unclear whether feedback left on these pages or to these accounts is even seen by the relevant practitioners or service providers. However, Greaves et al.'s study (2014a) does seem to suggest that some patients want to use Twitter to leave feedback about hospital care, but it is not clear whether this would apply to general practice too. It is also unknown whether there are particular circumstances where patients may consider leaving feedback on social media, instead of using other feedback methods.

Likewise, patients are also leaving feedback and reviews for GPs and GP practices on generic rating websites, such as Google+. As the Google+ page is normally the first link in a Google search about a GP practice, the use of Google+ to review GPs and practices may be increasing, and may be of more concern to GPs and their practices because of its visibility, the lack of control over the content, lack of moderation, and

it may be extremely difficult to get anything removed from such websites. For patients, these websites require that their name be left, and hence the patient would then be identifiable; and it is unknown whether this may deter patients from leaving feedback on such websites.

Websites to give feedback privately to GPs – Just as patients can give feedback privately to their GP by writing a letter to them; patients could also use a private form on a GP practice website (or any other website) to send their feedback. However, this service is not provided by all GP practices, and some GP practices do not even have websites. Websites such as MyHealthLondon (http://www.myhealth.london.nhs.uk/) whose aim is to provide a comprehensive reference point for health services across London allowed patients to use their website to send feedback privately to their GP or GP practice. However, in Apr 2015, this section of their website was not working, and in June 2016, it was offline. The CareConnect website discussed earlier also allowed private feedback to be sent to health service providers, including GPs.

Summary – This section illustrates that there are different ways patients in England can leave feedback about their GPs using the internet. Table 3-1 summarises the different OPF websites in England and their characteristics. This research focuses on specialist OPF websites only, such as the NHS Choices website or iwantgreatcare.org.

A review of the different OPF websites raises questions such as whether GPs and GP practices and patients are looking at and using OPF, whether patients want to leave feedback anonymously or not, whether patients prefer to leave feedback on a physician-based OPF website or a practice-based OPF website, and also why patients would or would not consider using such websites. Understanding these issues may assist in improving OPF websites to tailor them to patients' and healthcare providers' needs, and may also contribute to increased usage of these websites.

Table 3-1: Characteristics of websites in England (as of June 2016) where patients can leave feedback for their GP publicly

Name of website	GPs in which region?	NHS Led	Specialist for Healthcare?	Can patient leave feedback anonymously?	Comments manually moderated before being published	Can a GP be named?	Is the GP alerted of feedback?	Is there an official way for GP to respond to the feedback?	Can false feedback be challenged and removed?	Tracks real-time change	Multiple channel feedback
NHS Choices	England	✓	✓	✓	✓	×	✓	✓	✓	×	×
iwantgreatcare	UK	×	✓	✓	×	✓	✓	✓	✓	×	×
Careconnect (offline in April 2015)	London	✓	✓	✓	✓	×	✓	✓	✓	✓	✓
Patient Opinion	Sheffield only	×	✓	✓	✓	✓	✓	✓	✓	✓	✓
Facebook	World	×	×	×	×	✓	×	×	×	×	×
Twitter	World	×	×	×	×	✓	×	×	×	×	×
Google+	World	×	×	×	×	✓	×	×	×	×	×

3.3 OPF IN ACADEMIC LITERATURE

Two systematic reviews on OPF can be found in the literature: Emmert et al. (2013b) conducted a systematic review of articles published about doctor rating websites prior to May 2012, and Verhoef et al. (2014) conducted a scoping review of literature published before 2014 on social media and ratings as tools to understand the quality of care. This literature review expands on those reviews, and takes a different approach to thematically analysing the literature by distinguishing between evidence-based findings from empirical studies and anecdotal comments reported in academic literature.

The academic literature used in this review was collected over the period of 2011-2016 and stored thematically in Mendeley software. There were two instances during this period (Dec 2011 and April 2016) where a systematic search was conducted on twelve academic databases (OvidSP, ASSIA, Ebsco, Science Direct, Taylor & Francis, Springer, Google Scholar, Wiley, JSTOR, PubMed, Web of Knowledge and Cochrane Library) using the following fifteen search phrases: i) physician rating sites, ii) online+patient feedback, iii) "Patient Opinion", iv) "NHS Choices", v) "patient feedback", vi) NHS+"patient feedback", vii) web based feedback, viii) patient feedback+quality, ix) web+patient feedback, x) use+patient feedback+quality, xi) web+feedback, xii) web+"patient feedback", xiii) internet+patient feedback, xiv) patient survey, and xv) patient experience.

3.3.1 Overview

The introduction of OPF websites polarized debate, and arguments for and against can be found narrated anecdotally both in academic and non-academic literature from 2008, as shown in Figure 3-4. On the one hand those that advocate OPF websites (mainly owners of the websites and journalists) argue that feedback in the public domain is beneficial to patients, healthcare providers and the wider healthcare industry. On the other hand, critics of OPF websites (mainly physician representatives) question the validity of the feedback left online by arguing that the feedback is not an accurate measure of the quality of care, and therefore it cannot be used for improvement, or for patient choice, and inaccurate results can therefore also harm the healthcare providers' or doctors' reputation.

As shown in Figure 3-4, academics have taken two distinct approaches to address the criticisms of OPF. The first group of academics measured whether there was an association between online ratings and other traditional measures of quality, in an attempt to prove that online ratings were an accurate measure of quality. The second group of academics chose to address the underlying factors as to why online ratings or reviews may not be accurate measures. It can therefore be seen that academics have to some extent scrutinised and questioned the validity of ratings and reviews on OPF websites, and this will be discussed in detail in the forthcoming sections. However, as shown in Figure 3-4, what has not been explored in research studies is whether OPF is of some value and importance to patients, healthcare providers or doctors, and the wider healthcare industry.

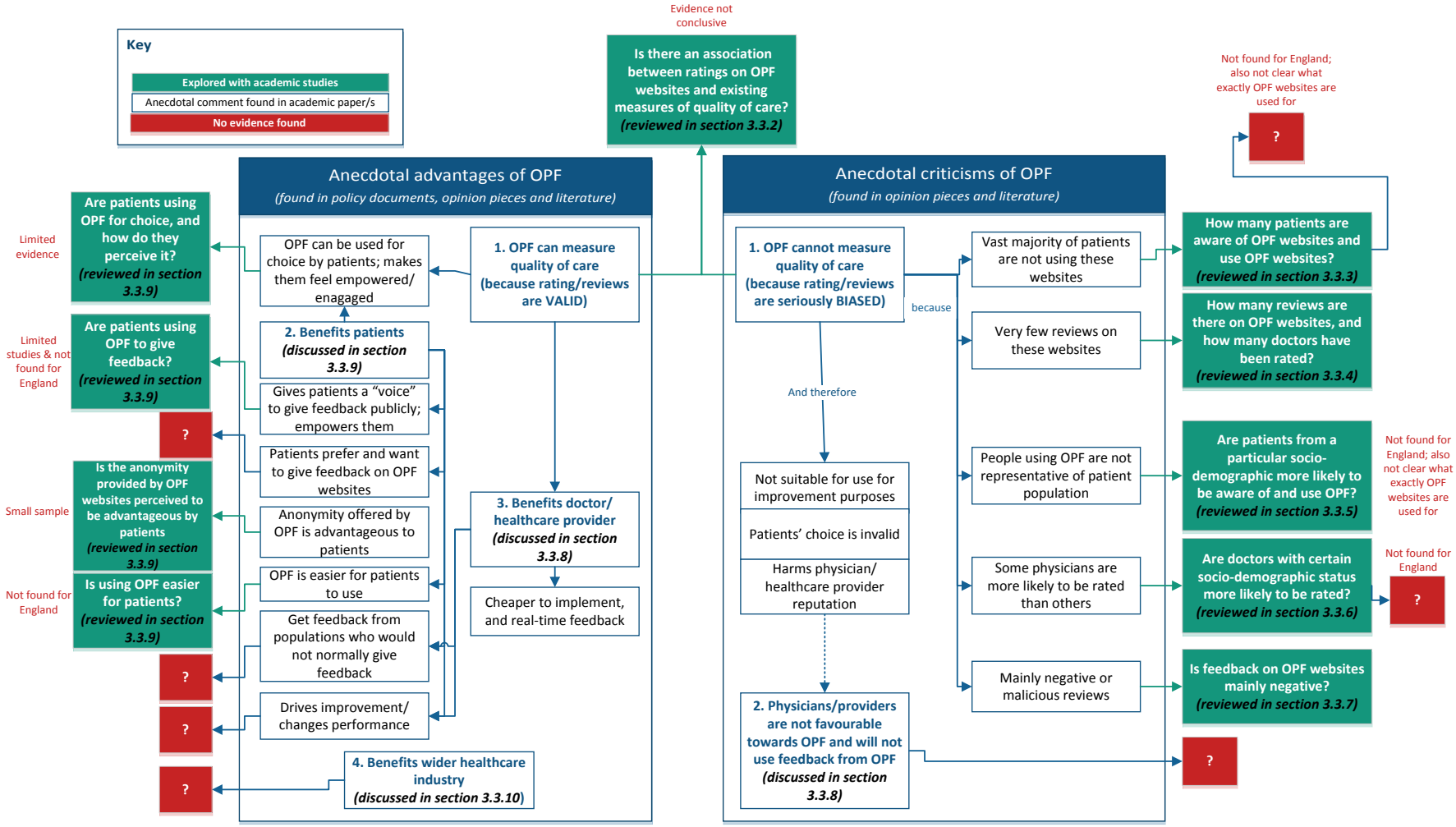


Figure 3-4: Arguments for and against OPF found in academic literature

3.3.2 Is there an association between ratings on OPF websites and quality of care?

As shown in Table 3-2, five studies have explored the association between ratings on OPF websites and measures of quality. Amongst them was Greaves et al. (2012a) who found an association between hospital ratings on the NHS Choices website (between 2009-2010) with patient experience data from conventional surveys in the same period. Furthermore, they found that clinical outcomes, such as mortality rates and readmission rates were as strongly correlated with online ratings as they were with the national patient experience survey data conducted using random sampling. Researchers in the USA also found the same associations as Greaves et al. (2012a) when they explored associations between a national sample of hospital ratings on Yelp.com with traditional measures of quality (Bardach et al. 2012). This, they suggest, proves that online patient ratings can play a vital role in improving quality and safety, and Greaves et al. (2012a) recommend that healthcare providers should encourage their patients to use OPF websites.

However, for general practice ratings on NHS Choices, Greaves et al. (2012b) found that although the online ratings were moderately associated with patient experience measures, they were weakly associated with clinical quality, suggesting further research is needed. Gao et al. (2012) also suggested the same, because although they found associations between ratings on RateMDs website and the quality of the physician (such as board certification and mortality), they suggested that the magnitude was 'small'. The ratings were also based on a small number of reviews, and most of the ratings were reflections on punctuality and staff, which may not necessarily be evaluations of the quality of care provided by the physician.

Using a sample of 600 physicians, academics in the USA also explored the association between surgeon volume (the number of surgeries performed by the surgeon as a proxy for clinical outcomes and safety) and online reputation from nine websites (Segal et al. 2012). They found that the total number of reviews correlated weakly with surgeon volume, but the actual rating value did not. Despite this, they still suggested that this provides evidence that patients can use doctor rating websites to identify better quality surgeons.

Table 3-2: Correlations between information from OPF websites and measures of quality.* Adapted from Verhoef et al. (2014)

Article	Info from website	Patient experiences	Readmission rates**	Mortality**	Board certification	Education	Malpractice claims	Infection rates	Clinical quality indicators	Surgeon volume
(Bardach et al. 2012)	**Hospital rating**	**+**	**+**	**+/-**						
(Gao et al. 2012)	**Physician rating**				**+**	**+**	**+/-**			
(Greaves et al. 2012a)	**Hospital rating**	**+**	**+**	**+/-**				**+**		
(Greaves et al. 2012b)	**GP rating**	**+**							**+/-**	
(Segal et al. 2012)	**No of reviews**									**+**
(Segal et al. 2012)	**Rating value**									**-**

*This table presents the correlations or associations as presented by the authors in their papers.
**Different measures used.
Key: + = there is a correlation; +/- = correlation is weak or not found for all aspects; - = there is no correlation

Having reviewed the literature, it seems that although some associations have been found between online ratings and other measures of quality (and this is promising), for 3/5 of the studies the effect size was found to be weak, and more importantly, for all of the studies, the number of comments left online (the sample) for each physician/hospital was small. So for example, in Greaves et al.'s study (2012b) with general practices in England, the mean number of ratings per practice was only 2.1. A more rigorous association can only really be determined once there are a larger number of reviews, and the effect of the correlation is consistent rather than conflicting. Therefore, as Burkle and Keegan (2015) also recommend, more studies need to be conducted to determine whether an association exists between online patient ratings and other measures of quality. However, the current studies (as shown in Table 3-2) do hint towards the huge potential benefit of using OPF websites for quality improvement, and also suggest that patients may be using correct measures when using these websites to exercise choice.

3.3.3 How many patients are aware of OPF websites and use OPF websites?

One of the criticisms made by physician representatives against OPF websites is that the vast majority of patients are not using OPF websites and therefore any feedback left on them (whether in the form of ratings or reviews) are not representative of the true patient experience, and the quality of care provided by a healthcare provider

(McCartney 2009). Several academics have sought to address this, conducting studies to explore both the level of awareness and usage of doctor rating websites.

Patient awareness of OPF websites – In Galizzi et al.'s (2012) survey based study in one borough of London, it was found that only 15% of the public were aware of doctor rating websites. However, the sample size of the study was small (n=200), and a convenience sample was used. Furthermore, the study did not specify for which purpose/s patients were aware of doctor rating websites (for feedback or choice, or for both), rather they were asked generally about their awareness of specific doctor rating websites.

Outside England, higher levels of awareness were found, with the highest being 65% (1389/2137) in the USA according to Hanauer et al. (2014a). In Germany, 29.3% (289/986) of the public were aware in 2012 (Terlutter et al. 2014) and 32% (483/1505) in 2013 (Emmert et al. 2013a). The higher levels of awareness may be partially explained by the higher usage and popularity of private healthcare in both countries, but there could also be sampling effects, because the studies were all conducted using online panel sampling.

Patient usage levels – As discussed earlier in the chapter, OPF websites can be used by patients to leave ratings or reviews (for feedback), and/or use patient feedback on the website to select a provider (for choice). In England, Galizzi et al. (2012) found usage of doctor rating websites at only 3% (6/200). The purposes for which patients had used the website were not clear, however.

Usage of OPF websites has been found to be much higher outside of the UK. A recent study in the USA (in Rochester Minnesota) found that 16% (137/854) of patients had used a doctor rating website to exercise choice; and 3% had used it to leave feedback (Burkle and Keegan 2015). This was different to another study in the USA, conducted in 2012 by Hanauer et al. (2014a) which found parental usage of OPF websites for choice at 28% (453/1619); and usage to leave ratings at 6% (97/1619). The difference may be partly because the latter study used an online panel as the survey mode, and the former study used a written questionnaire conducted in a single setting.

In Germany, in 2013, 25% (381/1505) of the public were found to have searched for a doctor on a doctor rating website, and 11% (166/1505) had posted a rating (Emmert et al. 2013a). Similarly, Terlutter et al. (2014) also found in Germany in 2012 that 26%

(257/986) of the population had previously used a doctor rating website. However, the reasons for use were not identified.

In Austria, researchers conducted an experimental study based on a convenient sample and found that 47% (78/166) of respondents had used a doctor rating website to exercise choice, and 6% (10/166) had used it to leave feedback (Grabner-Kräuter and Waiguny 2015). This is the highest level of usage found so far.

The differences in the level of usage of OPF websites across different countries may be due to regional variations in the diffusion of doctor rating websites, however there may also be a sampling effect, because all of the studies outside of the UK (with the exception of Burkle and Keegan (2015)) used an online panel as their sample population. This may have affected results, as those that are online may be more likely to be aware of and use doctor rating websites than those that are not online. Despite this, all of the studies conducted outside of the UK indicate that patients are more likely to use OPF websites to choose a healthcare provider/physician rather than leave feedback. It is unknown whether the same would be found for patients in England too, and if that is the case, it would be useful to know why patients may be more likely to use OPF websites for choice rather than giving feedback.

3.3.4 How many reviews are there on OPF websites, and how many doctors have been rated?

Studies have illustrated that the content of OPF is broad (Black et al. 2009; Emmert et al. 2014; Ferrara et al. 2014; Kadry et al. 2011; Lagu et al. 2013; López et al. 2012; Trehan et al. 2016), with comments ranging from the quality of care to facility provisions. Yet critics of OPF websites still argue that there are very few reviews on OPF websites, and very few doctors have been rated. A study on the NHS Choices feedback site found that 61% (4950/8089) of GP practices in England had been reviewed, and the number of ratings left per practice were variable with a mean average of two ratings per practice (Greaves et al. 2012b). This number of primary care reviews is higher than those noted in the USA and Germany (more details below), and this may be because the English ratings are per practice (which usually have a few GPs each) and not individual ratings of GPs, which would probably put the number of GP's reviewed lower. This is difficult to verify because feedback on the NHS Choices website is anonymous to GPs. Furthermore, this study explored data

from over 5 years ago (between the period of Oct 2009 and Dec 2010) and more up to date analysis of the website is required to understand the current state, as usage may have altered. However, reviews on the NHS website in the same study were found to only correspond to 0.005% of all GP consultations (Greaves et al. 2012b), which is in fact very low.

In Australia, the number of ratings were even lower, where only 4.4% of doctors registered on three different rating websites were found to be rated (Atkinson 2014), suggesting that OPF is still in its infancy in Australia. In the USA, this number was higher: 16% (112,000 out of approx. 700,000) of national physicians were rated with a mean average of 3.2 number of ratings per physician (Gao et al. 2012); 27% (81/300) of Boston physicians were rated with a mean average comment of 2.3 per physician (Lagu et al. 2010); 28% (53/250) of randomly selected internal medicine physicians were rated with 1-4 reviews (Mostaghimi et al. 2010); 2.4 ratings on average were found per urologist from a selection of 500 urologists (Ellimoottil et al. 2013). More recently, rather surprisingly, 98% (245/250) of a random sample of hand surgeons in the USA were found to have at least one rating online (Trehan et al. 2016).

In Germany, the overall mean percentage of rated physicians was found to be between 3% and 26% (Emmert et al. 2009), and between 3% and 28% (Strech and Reimann 2012). A more recent study found that 37% of all German doctors had been rated on Jameda with a mean of 2.37 individual ratings (Emmert and Meier 2013). This increase is in-line with findings from China where 37% of all doctors were found to have ratings on the Good Doctor website (Hao 2015), and from Greaves and Millett (2012) who found that the number of ratings of hospitals in England posted on NHS Choices was consistently increasing between the period of Aug 2008 (when the website started) and the end of 2011, although the increase was not at the same rate as the USA. With internet usage for health information increasing steadily in the UK (Office for National Statistics 2013a, 2015a), further studies are required to explore more up to date usage information of OPF websites in England.

It must be noted however that making comparisons across countries is not always accurate because the datasets in the different studies (from different countries) were collected differently, used different samples and sample sizes, and the timeframe of the data sets was also different (Hao 2015). However, what all of these studies do indicate is that although the number of online reviews about healthcare providers

appears to be increasing in USA, Germany, and England, the number of reviews per physician is still low.

This suggests that OPF websites have not permeated the population in England, and that OPF websites cannot be used alone as the only metric to measure patient experience. Tanne (2013) also argues that this indicates that these sites need many more reviews to make them reliable. Internet usage is increasing, and it may be that OPF usage levels have increased too since the studies were conducted. Furthermore, it is not clear how this compares to feedback collected from other unsolicited means, such as paper-based feedback cards, and research is required to explore this.

3.3.5 Are patients from a particular socio-demographic profile more likely to be aware of and use OPF websites?

Another criticism against OPF websites is that the people who are using them are not representative of the population at large, and hence the reviews found on these websites will also not be representative of the patient experience. Therefore patients should not use these reviews to exercise choice, and healthcare providers need to use these reviews with caution. Academics have sought to address this concern by exploring whether specific groups of patients were more or less likely to be aware of and use doctor rating websites.

Predictors for awareness of doctor rating websites have been explored by Galizzi et al. (2012) in London and by Emmert et al. (2013a) in Germany. Galizzi et al. (2012) found that those younger in age, or ethnically white, or those when deciding where to receive care either give importance to the reputation of the doctor or to hospital statistics, are more likely to be aware of doctor rating websites. In contrast, Emmert et al. (2013a) found in Germany that female respondents, or those widowed, or those with higher healthcare utilization were more likely to be aware of doctor rating websites.

Predictors for usage of OPF websites by patients in the UK could not be found in any studies. However, Galizzi et al. (2012) reported the predictors for the intention to use doctor rating websites in the future, although they did not specify the purpose for which the website would be used by patients (choice or feedback or both). More surprisingly, they did not report the level of intention for future use. They did

however find that income, ethnicity and the doctor-patient relationship were significant predictors of future intention to use doctor rating websites.

Other studies outside England did report predictors of usage of doctor rating websites. In Germany, advanced education, advanced digital literacy, presence of a chronic disease, less importance given to family and pharmacist for health information, more importance attached to the internet for health information, more trust in information on doctor rating websites, and a higher judgment of the usefulness of doctor rating websites, were all found to be significant predictors of usage of doctor rating websites (Terlutter et al. 2014). Another study in Germany found that marital status, health insurance coverage and healthcare utilization were the significant predictors for usage of OPF websites (Emmert et al. 2013a). In the USA, age and gender were found to be significant by Hanauer et al. (2014b) with women more likely to have posted ratings and those younger in age, and Burkle and Keegan (2015) also found that younger patients had visited a doctor rating website more than those over the age of 50. This is expected given that younger people are more likely to use the internet.

The different predictors found in the aforementioned studies suggest that OPF is not fully representative of the population at large; and when used, user characteristics need to be looked at. Further research is required to determine whether the different predictors for awareness found in London could be found across England, and also whether there are any predictors for usage of OPF websites in England. These could be used to determine not just whether feedback left on OPF is representative, but also which population groups are not using OPF websites to leave feedback or to exercise choice, and explore measures that could be used to increase their usage of OPF websites.

3.3.6 Are doctors with certain socio-demographic status more likely to be rated?

A study in the USA found that physicians who were male, older in age, or those that were board certified or had at least one malpractice claim, were more likely to have been rated online (Gao et al. 2012). They also found that primary care doctors were more likely to be rated than secondary care doctors (such as surgeons). Further research is required to determine whether this applies to doctors in England. Other

than this, there is little evidence to prove that doctors with certain socio-demographics are more likely to be rated (Emmert et al. 2013b).

3.3.7 Is feedback on OPF websites mainly negative?

A popular criticism against OPF is that feedback on OPF websites is mainly negative, and this concern has been raised in opinion articles (Boffey 2011; McCartney 2009) as well as academic literature (Gao et al. 2012; Merrell et al. 2013). The claim has been counteracted by the argument that many studies have found that the majority of feedback left on OPF websites is in fact positive (Alemi et al. 2012; Atkinson 2014; Black et al. 2009; Detz et al. 2013; Emmert and Meier 2013; Emmert et al. 2014; Gao et al. 2012; Greaves et al. 2012b; Hao 2015; Kadry et al. 2011; Lagu et al. 2013; Lagu and Lindenauer 2010; López et al. 2012; Trehan et al. 2016). However, it is unknown how many negative reviews are left by patients on OPF websites but not published by the owners.

Furthermore, two studies from England (Greaves et al. 2012b; Lagu et al. 2013) that analysed reviews given on the NHS choices website found that although they were in line with the positive nature of responses (with 64% recommending primary care and 68% recommending acute hospitals), they were significantly lower than ratings from other studies, such as the one from Germany that found ratings of individual physicians were 80% positive (Emmert et al. 2014). Greaves et al. (2012b) suggest that this may be because NHS Choices is a government run website and is more likely to have less satisfied patients than a privately owned website. Another possible explanation for this may be that the NHS ratings are based on both practices and GPs – an all in one score – whereas the physician ratings in the USA and Germany are for physicians alone, and it may be that well known problematic issues related to practices (such as rude receptionist staff or difficulties associated with getting an appointment) may be bringing the overall practice-based score down. This needs to be explored in further studies.

More importantly, Greaves et al. (2012b) found that the recommendation level of GPs and practices online was lower (64%) than an in-patient survey where 82% were recommended for the same period. They suggest that this indicates there may be a selection bias in OPF towards less satisfied patients in comparison to when patients are selected randomly. Others have argued that the abundance of positive reviews

cannot negate the impact of negative ones, since negative comments, however few, can have long lasting ramifications on physicians or healthcare providers (Merrell et al. 2013).

In summary, although it is difficult to compare across studies (because they were collected using different sample sizes; different modes, and at varied time periods), the nature of feedback on OPF websites is reported as largely positive, and not mainly negative as critics of OPF suggest. However, what is important to determine in future studies is whether patients are equally likely to leave both positive and negative feedback online.

3.3.8 How do healthcare providers perceive OPF?

Physician representatives have been the greatest critics of OPF, especially when OPF websites were first launched in the UK, during the period of 2005-2009. They argued that OPF is biased towards the negative, is unrepresentative, and will not improve the quality of care, but rather will negatively affect physicians' reputation and wellbeing (Coombes 2009; Dolan 2008; Lagu et al. 2010; McCartney 2009; O'Dowd 2009). A similar outcry from healthcare professionals in Germany was also reported (Hotopf 2013). However, the owners of the websites dismissed such claims, with the owner of a German OPF website (Jameda.de) describing doctors as the 'elite' who are not used to receiving patient feedback (Hotopf 2013), while a UK website owner (iwantgreatcare.org) described OPF as a throwback to 'medical paternalism' (Bacon 2009). Others argued that OPF can drive improvement (Greaves et al. 2012a), and that OPF websites collect feedback from those patients who would not normally leave feedback (Bardach et al. 2012).

Concerns were also raised about malicious intent from patients, and a few physicians admitted that they wrote reviews about themselves (Solomon 2007). More recently, a handful of doctors in the USA were reported to be so angry about some online reviews left about them that they revealed patients' intimate data online (Ornstein 2016). No empirical study as yet explores whether physicians really feel this way, and most of the concerns were reported anecdotally in 2009 when the NHS Choices website and other OPF websites were first launched. It would not be surprising if physicians' attitudes towards OPF websites may have shifted since 2009, especially

because of the increase in usage of consumer rating websites like Trip Advisor and the emergence of the digitally engaged patient, as discussed in Chapter 2.

In addition, a recent small qualitative study with 13 healthcare professionals in England by Speed et al. (2016) found that the anonymous nature of OPF comments were perceived to be of little use to healthcare professionals, and they were concerned about the impact of those anonymous comments on their reputation. There is also little known about whether doctors are even aware of OPF websites, whether they reply or use the feedback received from such websites, and what their attitudes are towards them (Emmert et al. 2013a).

3.3.9 How do patients perceive OPF?

Those that advocate OPF argue that the benefits of OPF websites to patients include the following: i) it gives patients a 'voice' to publicly narrate and give feedback about their experience of receiving healthcare, and therefore also empowering them as a result (Lagu et al. 2010); ii) it makes patients feel like they are helping others and doing their citizen duty (Lupton 2013); iii) it gives those patients who would not normally give feedback the opportunity to leave feedback (Bardach et al. 2012); iv) it is easier for some patients to leave feedback online (Entwistle et al. 2003); v) some patients would prefer to give feedback using OPF websites rather than other methods (Lagu et al. 2010); vi) patients can leave anonymous feedback online, whereas sending a letter or an email does not guarantee anonymity (López et al. 2012); vii) it allows patients to choose a provider based on patient reviews, again making them feel empowered (Lagu et al. 2010); and viii) the transparent nature of the feedback left online will drive improvement, which will benefit patients (Davidson et al. 2010).

The above eight benefits have been mentioned in academic literature. However, only three have been explored in academic studies. The first is patient choice (point vii above), the second is that some patients find it easier to leave feedback on OPF websites (point iv above), and the third is the anonymity afforded by OPF websites benefits patients (point vi above). These are discussed in detail below; and the remaining five perceived advantages are anecdotal reports that require evidence to prove they are true.

Are patients using OPF for choice, and how do they perceive it? Critics of OPF argue that it can be damaging when patients use OPF in order to choose a provider,

because patients who are less informed are unable to recognise whether a review they are reading is influenced by the writer's personal preferences and expectations, and also whether the writer had the ability to assess the doctor's performance (Trigg 2011). However, those that advocate OPF argue that reviews are there to measure the quality of care provided to patients, and OPF is used as a separate but complementary measure to the assessment of the doctor's technical competency (Trigg 2011). However, there is little evidence currently to support either of these claims.

Some studies assess whether patients are using OPF in order to choose a provider. In England, the National Patient Choice Survey in 2010 conducted with 69,040 members of the public found that only 6% of respondents (4142/69,040) had used the NHS Choices website to choose a healthcare provider (Dixon 2010). This is in contrast to higher usage levels found in Germany and the USA, as discussed below, although the sample sizes were considerably smaller.

A study conducted with online patients (n=1505) in Germany found that 25% of respondents (381/1505) had searched for a physician on a doctor rating website, whereas only 11% (166/1505) had posted a rating on a doctor rating website (Emmert et al. 2013a). Similarly, a survey conducted with 2137 patients from an internet based panel in the USA found that 25% (543/2137) had used a rating website in the past to read a review about a physician (Hanauer et al. 2014b). In contrast, another study conducted in the USA with 854 consecutive patients at a clinic in Rochester Minnesota (using a paper-based survey) found that only 15% (132/854) had used a doctor rating website to choose a provider, and 3% (24/854) had used it to leave feedback (Burkle and Keegan 2015).

The difference in results may be explained by one sampling population being exclusively online; however, at a closer glance, Hanauer et al. (2014a) actually found that of the 25% of people who had accessed a doctor rating website to read a review, only 35% of them had selected a doctor based on good ratings, and 37% had avoided a doctor based on negative ratings. This suggests that accessing a doctor rating website to look for reviews does not necessarily indicate usage for choice. It would be useful to explore why those who had searched for physicians on a doctor rating website had not used the ratings to choose a physician.

The study in question (Hanauer et al. 2014b) did explore the importance patients attach to using reviews on doctor rating websites to make a choice of provider (although not for leaving feedback). They found that 59% of people (1260/2137) reported doctor rating websites to be 'somewhat important' or 'very important' when choosing a doctor, but doctor rating websites were reported as less important than a recommendation from a family member or friend. From those that had not searched for online ratings, 43% said they did not trust the information on the website (Hanauer et al. 2014b).

In a study conducted in the USA by Burkle and Keegan (2015) mentioned earlier, 81% agreed or strongly agreed that a positive review alone on a doctor rating website would cause them to seek care from that physician, and similarly for a negative review, 77% agreed or strongly agreed that it alone would cause them to avoid seeking care from that physician. The difference in results may be because the sampling method used was different (online panel and paper-based survey), and the latter study (Burkle and Keegan 2015) was conducted on a single site. Nevertheless, both studies suggest strongly that at least in the USA, more than half of patients attach strong importance to using reviews on doctor rating websites when choosing a provider. Whether the same could be said for using doctor rating websites to leave feedback is unknown.

However, there is very little evidence to suggest that this is the same for patients in England. A qualitative study with three focus groups conducted by The Nuffield Trust (2013) to gauge public attitudes towards health and social care ratings found that an overall rating for GP practices (as is currently on the NHS Choices website) was not as useful for choice nor practical, and hence people relied more on word of mouth to choose a GP. Furthermore, the considerably lower levels of usage (at 6%) of the NHS Choices website for choice in England in comparison to Germany and the USA may suggest the same. However, the difference may be because the English study was conducted over 5 years ago (Dixon 2010), and usage of OPF for choice may have increased now. Also, due to the dominance of private healthcare in Germany and the USA, it is not surprising that doctor rating websites are more popular in Germany than in the UK, and the study participants in the Germany based study were also mostly covered by private healthcare insurance (Emmert et al. 2013a). Furthermore,

the study in England only explored usage of NHS Choices websites, and did not explore usage of other OPF websites in England for choice.

Research is therefore required to explore whether patients in England want or need online patient reviews to choose a provider, or whether they prefer other metrics to choose a provider, such as their GPs' recommendation. There is also little known about whether GPs or other clinicians or even the NHS is encouraging patients to use the NHS Choices website for choice. Similarly, there is very little known about whether they are encouraging patients to use the NHS Choices website to share their experience and leave feedback.

Is using OPF easier for patients? Only one study could be found in the literature that explored this benefit. Researchers conducted a study with 1951 Scottish NHS patients in 2002 (using random sampling) exploring patients' opinions about different feedback methods in the NHS, preferences for certain methods over others, and their likely effectiveness (Entwistle et al. 2003). Amongst these methods was a hypothetical NHS feedback website where patients could submit feedback which would be passed on to relevant staff. The website was not described as one where patients' feedback would remain in the public domain, therefore it cannot be characterised as an OPF website or a doctor rating website. Nevertheless, the study found that 0.9% of patients said they would use such a private NHS feedback website over other methods. The most frequently cited reasons patients gave were: because it was easier, more convenient and quicker. They also mentioned that it gave them time to think about what they were going to say, they would have a record of the feedback they gave, they could remain anonymous, they would not have to confront staff directly, and it would not waste NHS staff time.

However, it must be reiterated that although the findings of this study may suggest that some patients found giving feedback on a website easier than using other methods, the website in question that patients were asked about was not an OPF website, rather it was a private website where feedback would not be placed in the public domain. Furthermore, only 0.9% of patients actually preferred a private feedback website to other methods, a considerably small number. Since 2002, usage of the internet and rating websites has of course increased, and so has the emergence of the digitally engaged patient, as discussed in Chapter 2. Consequently, it could be that more patients prefer to use an OPF website that displays their feedback in the

public domain too. Research is therefore required to explore this, as well as what may motivate patients to leave feedback on OPF websites (rather than other feedback methods available in primary care), and whether patients perceive giving feedback about healthcare providers/doctors in the public domain as advantageous or disadvantageous to them, their fellow citizens, their doctors and the NHS.

Is the anonymity provided by OPF websites perceived to be advantageous by patients? A recent qualitative study explored the concept of anonymity in web-based comments with ten patient bloggers and eighteen patient representatives (Speed et al. 2016). The study found that patients believe that the ability to remain anonymous is vital for the use of OPF feedback websites. This was not so much because of concerns about their own privacy, but mainly due to the fear of being identified, and concerns about how that would have an impact on the care they receive in future. However, this study was small, and a larger more representative sample is required to determine whether patients would consider leaving non-anonymous feedback about a healthcare professional online.

3.3.10 Does OPF benefit the healthcare industry?

As discussed in section 2.4 of Chapter 2, patient experience when reported in the public domain is argued to be an evaluation tool that can be used by commissioning boards and the government to measure standards and quality, and assess performance, resulting in healthcare providers being more accountable (Jabbal 2016; Robert and Cornwell 2011). Whilst this may be true, there is little evidence yet to suggest that commissioners and the NHS are using patient experiences narrated online for this purpose.

Lupton (2013) suggests that the digitised patient experience presented on OPF websites is of benefit not just to the healthcare provider and the patient, but also to the healthcare industry as a whole, because the experiences can be used to conduct medical research, train doctors and develop better interventions and medical treatments. However, the digitised reviews or feedback are also being sold to third parties for commercial purposes. This may indicate the multiple benefits of OPF, but Lupton (2013) argues that patients are not aware that the experiences they are sharing are becoming valuable commercial commodities; and patients are not being given any financial remuneration, in fact they are being persuaded to share their

experiences for the good of society. Ethical questions are therefore raised for this practice. Further research is required to explore the extent to which patients are aware their data could be used for other purposes, and whether they would expect remuneration, as well as how far this practice (selling data to third parties) is common amongst OPF website providers.

3.4 RESEARCH OPPORTUNITY

After reviewing both academic and non-academic literature in this chapter and in Chapter 2, many research opportunities can be identified, and this is not surprising given that OPF is still in its infancy. These opportunities are shown in Figure 3-4 (in red), and amongst them are the following:

Patient awareness, usage, predictors and attitudes towards OPF - As discussed in the previous section, patient awareness, usage and predictors have been explored for some patients in London and outside England. None of the studies compared awareness, usage or predictors to other methods of collecting feedback that are available to patients, which means that it is difficult to truly determine usage or awareness outside of its context. It is also not clear whether OPF is filling a 'feedback gap'.

No study could be found in academic literature (in the UK or elsewhere) that explored patient attitudes or motivations for using OPF websites (Powell et al. 2015). It is also unknown for example whether patients prefer to remain anonymous when they leave feedback online, or whether they prefer to leave feedback on practice-based rating websites rather than physician-based rating websites.

Healthcare providers' (or physicians') awareness, usage and attitudes towards OPF – Although there has been some criticism of OPF websites reported from a few doctors or physician representatives in opinion pieces, newspaper articles, and journals, no studies could be found that explored healthcare providers' or doctors' awareness, usage or attitudes to OPF. Healthcare professionals, including doctors and healthcare providers are the key users and targets of OPF; yet there is little evidence to demonstrate if and how they are using them. Understanding how they perceive OPF (perceived benefits as well as concerns) for both receiving patient feedback and patient choice may help eliminate some of the concerns they may have, and give an

understanding of whether digitised patient experience feedback (i.e. OPF) is of any value to them, and whether they would consider using OPF to improve their practice.

Other research gaps were also identified, such as whether OPF is being used for improvement, quality monitoring purposes or commissioning in the healthcare sector, and also the role that OPF plays for patient choice and whether it drives competition between providers, and consequently improvement. A decision was made at this point to focus the research on OPF as a mode for patient feedback rather than patient choice; because the researcher believed that through this mode improvement was more likely to be made than through the selection pathway.

3.5 RESEARCH QUESTIONS AND OBJECTIVES

Based on the literature review and research opportunities identified in the previous section, the research questions and main objectives are identified as follows:

'Are patients and GPs aware of online patient feedback websites as a channel for experiential feedback, and do they use them? What are their attitudes towards them? What are the implications of this for policy and practice?'

Objective 1 – To explore GPs' awareness, usage and attitudes towards online patient feedback websites as a mode for giving feedback about patient experiences of receiving care from GPs (Study A (Phase 1))

Objective 2 – To create and validate a questionnaire to measure patients' awareness, usage and attitudes towards online patient feedback websites as a mode for giving feedback about their experiences of receiving care from GPs (within the context of other feedback mechanisms available in general practice) (Study B (Phase 2) and Phase 3)

Objective 3 – To explore and measure nationally patients' awareness, usage and attitudes towards online patient feedback websites as a mode for giving feedback about their experiences of receiving care from GPs (within the context of other feedback mechanisms available in general practice) (Study C (Phase 4))

Objective 4 – Based on the findings of the studies, to produce recommendations for OPF website providers and GPs/GP Practices, and to inform policy and practice.

CHAPTER 4 - METHODOLOGY

4.1 INTRODUCTION

This chapter introduces the overall research methodology used to address the research questions, and the rationale behind selecting a mixed methods research design. The research questions (as shown in Chapters 1 and 3) were divided into sub-objectives, and these objectives were addressed in three different studies in this research (see section 4.3 below). A summary of methods used for each study is described in this chapter; however, the specific methods used to design and conduct each study are described in detail within their respective chapters.

4.2 RESEARCH UNDERPINNINGS AND PHILOSOPHICAL ASSUMPTIONS

Due to the scope of the research question, and the technological and health underpinnings of OPF, this research could be classified under the emerging research domain of digital health. Kostkova (2015) defines digital health as a multi-disciplinary research area which covers disciplines including computer science, information science, engineering, clinical medicine, public health, epidemiology, journalism, economics and others.

The choice of methodology and methods are explicitly or implicitly driven by philosophical (ontological and epistemological) assumptions (Creswell 2009), as illustrated in Figure 4-1. The researcher therefore needs to position him or herself paradigmatically, because awareness of philosophical assumptions not only clarifies and justifies potential methods used, but can also enhance the quality of research (Easterby-Smith et al. 2012). This is set out in the next section.

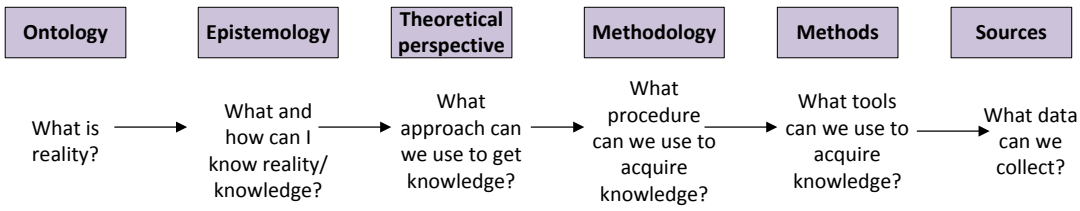


Figure 4-1: Ontology to Sources explained.
Adapted from Crotty (1998) and Hay (2002). First published on salmapatel.co.uk (the researcher's blog)

4.2.1 Philosophical paradigm and methodological theory

A methodological theory can either be paradigm-driven, or pragmatic (Punch 2013). This research takes a more pragmatic approach, where the methods were chosen based on the research objectives for each study (see Figure 4-2), which is a more practical and applied approach to research (Punch 2013). However, the underlying ontological position for this research as a whole was of subtle realism, as described by Hammersley (1992) and used by researchers such as Ritchie and Lewis (2003) and Mays and Pope (2000). Subtle realists make efforts to represent reality rather than attain 'the truth'. This is because they believe that there is an underlying reality in the world which can be studied, but at the same time acknowledge that subjective perception exists and that different research methods do produce different results (Mays and Pope 2000).

Using subtle realism as the ontological position means that the epistemological stance embraces aspects of positivism, constructivism and pragmatism, where appropriate (Ritchie and Lewis 2003). This meant that the research accommodated both qualitative and quantitative approaches (such as in Study C) and allowed a pragmatic and practical approach. It was appropriate paradigmatically for mixed methods, because it supported the understanding that there can be multiple valid representations of a given phenomenon (Mays and Pope 2000; Ritchie and Lewis 2003). This position allowed the researcher to evaluate the various perspectives of OPF (from GPs, patients and the public) offered by the different research methods and approaches, and to evaluate each against their own quality criteria (such as validity and relevance). The implications of using a subtle realist ontological position for this research is further discussed in section 4.4.

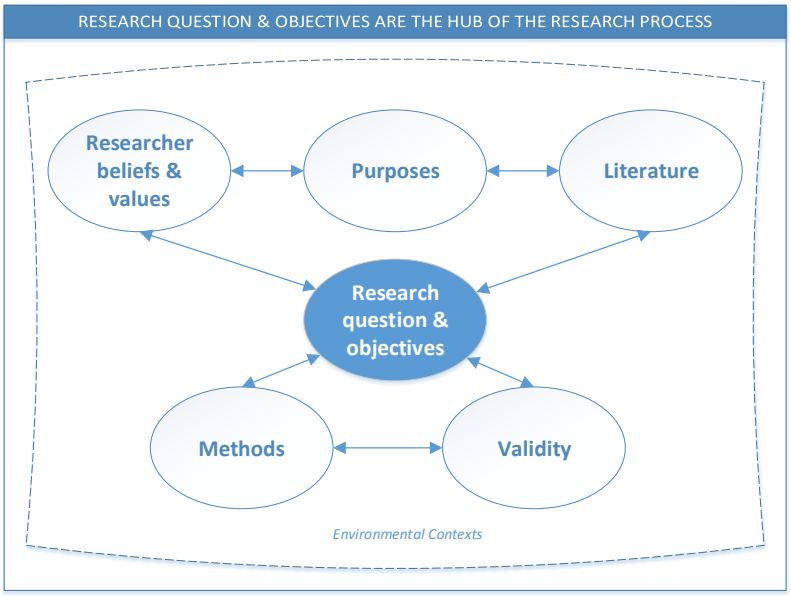


Figure 4-2: A model illustrating how mixed methods research is designed in response to research questions and objectives.
Adapted from Clark and Badiee (2010).

4.3 OVERALL RESEARCH DESIGN

A mixed method multi-phase design containing four phases was used for this research (see Figure 4-3). A multi-phase design is used when a topic or problem is explored through connected studies that are sequentially aligned, with each new study building on from the previous study (Creswell and Clark 2011). This type of design was used because OPF is an under-researched area (as illustrated in Chapter 3), and this type of research allowed for a set of incremental research objectives to be addressed, as findings emerged from each study and new questions arose (Creswell and Clark 2011). Furthermore, a single mixed methods study would not have answered the research question, because the aim was to understand OPF from both GPs' and patients' perspectives, both of whom are separate populations and require different approaches to study. Therefore, this multi-phase research (see Figure 4-3) consisted of two separate qualitative studies and one mixed methods study, which used a convergent parallel design.

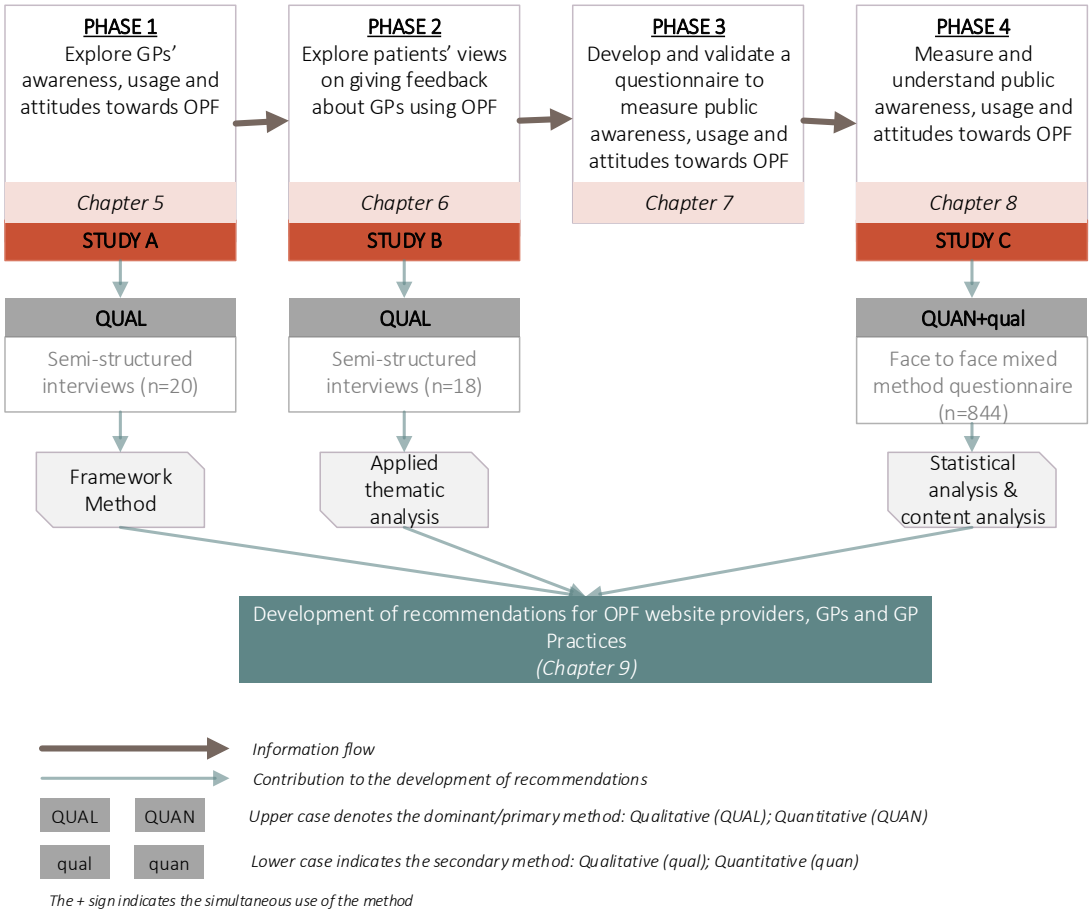


Figure 4-3: Overview of the multi-phase mixed methods research design

The absence of a substantive theory (a theory developed for a particular area of inquiry) in the area of OPF meant that this research was used in the main to build theory (theory generation), rather than to verify theory (theory verification). This has been suggested as a suitable approach by Wade et al. (2016) when existing theories cannot provide a suitable explanation for the phenomena; and this was appropriate given the absence of research that had explored OPF from GP and patient perspectives in the context of general practice in England.

The literature review conducted in Chapter 3 and the research gaps identified within the same chapter (section 3.4) illustrated that OPF is an under-researched area, and that specifically there is very little known about GPs' and patients' awareness, usage and attitudes towards OPF websites. Therefore, a descriptive exploratory study was used to explore GPs' (in Study A) and patients' (in Study B) views towards OPF. Exploratory research attempts to generate some initial insight into a relatively new or under-researched phenomenon or a phenomenon that is too complex, and it usually lays the groundwork for future research (for example, by interviewing key

informants) (Hesse-Biber and Leavy 2010). Descriptive research attempts to create an accurate factual picture of the issue under investigation, but does not attempt to show any causal links between variables. Conversely, explanatory research tries to explain the why and how of a phenomenon, as well as the relationship between different components of a phenomenon (Blanche et al. 2006; Hesse-Biber and Leavy 2010; Neuman 2013). Although an explanatory study has more applied value than a descriptive one, in areas where there is very little research, a good descriptive study may be of more value, since before attempting to predict or explain an attitude or behaviour, it first needs to be described (Adams and Lawrence 2014; Brotherton 2008). All three studies in this research were exploratory and descriptive in nature, but Study C was explanatory too.

Study A (Phase 1) – This study was exploratory, descriptive and qualitative in design. The purpose was to explore and describe GPs' awareness, usage and attitudes towards OPF. The literature review in Chapter 3 identified that very little was known about GPs' perceptions of OPF, therefore there was a need for in-depth exploration to capture complex attitudinal and experiential data (Tracy 2012), and a qualitative approach was best suited. The methods employed were semi-structured interviews (n=20), because this gave the depth required, opened up new areas to explore, and allowed probing. Interviews were transcribed verbatim and data analysis was carried out in NVivo using the Framework Method (Dixon-Woods 2011; Ritchie et al. 2013; Smith and Firth 2011), a form of thematic analysis.

Study B (Phase 2) – This study was also exploratory, descriptive and qualitative in design. The purpose was to explore patients' views on giving feedback to GPs, with a focus on OPF websites. Again, this type of design was used because the literature review in Chapter 3 identified that there was little understanding about why patients choose to leave feedback for a GP or why they refrain from doing so. Semi-structured interviews were used (n=18), which were transcribed verbatim, and analysed in NVivo using the Applied Thematic Analysis approach (Guest et al. 2012).

Phase 3 – In this phase, a mixed methods population questionnaire was developed that could be used to measure patients' awareness, usage and attitudes to the use of OPF websites to give feedback about GPs (at a population level so that the results are generalisable to all patients in England), and this measure was then validated. The questionnaire was developed by the researcher using the themes that emerged from

Study B and previous literature. It was thoroughly evaluated and validated based on the Total Survey Error Framework (see Chapter 7) using seven stages, which included multiple-stage expert reviews, cognitive interviews, and pilot testing.

Study C (Phase 4) – The mixed methods population questionnaire designed in Phase 3 was implemented in this cross-sectional study with 844 members of the public in England, so that a representative view of the public could be sought about OPF, which had not been conducted previously in England (see Chapter 3). A random location quota sampling strategy was used, and fieldwork was conducted by experienced interviewers from Ipsos MORI (a leading market research company) using the Computer Assisted Personal Interviewing (CAPI) technique. The results of the questionnaire were analysed using content analysis and statistical analysis. The questionnaire used a convergent parallel design. In this type of design, qualitative and quantitative data are collected in parallel, analysed separately and then merged (Creswell & Clark, 2011). The quantitative data was collected primarily to understand public views towards giving feedback to GPs, both online and offline, and the qualitative data helped explain the quantitative data. The two forms of data together bought greater understanding and insights into the topic area than would have been obtained by either type of data separately.

4.3.1 Rationale for a mixed methods research design

A mixed methods research design is practical because the researcher is free to use all methods possible to address the research question, but crucially it also provides more evidence for studying a research problem (Creswell 2009). In this research, this meant that as well as exploring qualitatively in Study B how some members of the public (n=20) viewed OPF websites, in Study C a representative view of the public in England was sought through a mixed methods questionnaire, which confirmed and complemented the findings from Study B. This pluralistic stance not only provides greater evidence, but can offset the weaknesses apparent in each method (Creswell and Clark 2011; Tashakkori and Teddlie 2010).

Combining both qualitative and quantitative approaches for a research design also helps answer research questions that cannot be addressed by quantitative or qualitative research alone (Tashakkori and Teddlie 2010). For example, the quantitative components of Study C tell us the extent of the public's usage of OPF

websites and how generalizable the results are, but it is the qualitative component which provides a deeper understanding of why that situation took place. The challenge with mixed methods is that it requires the researcher to have both qualitative and quantitative skills, as well as the time and resources to use both types of methods (Creswell and Clark 2011; Tashakkori and Teddlie 2003).

Mixed methods research design is increasingly being used in many disciplines including health services, psychology, sociology, education and business (Creswell and Clark 2011; Creswell 2009; Tashakkori and Teddlie 2010). Curry and Nunez-Smith (2014) and Ozawa and Pongpirul (2014) argue that mixed methods research is vital in health research because amongst other things, it allows a problem to be investigated from multiple perspectives, which results in a better understanding of the problem or phenomena. For example, qualitative research can be used to develop interventions or multifaceted construct measurement tools, such as a questionnaire, and this approach was used in Phase 3 of this research. This further supports the appropriateness of using a mixed methods design in this research.

4.4 RELIABILITY, VALIDITY AND GENERALIZABILITY

The ontological position for this research was subtle realism, therefore both qualitative and quantitative quality criteria were used where appropriate to assess the reliability and validity of each study (Giddings and Grant 2009; Ritchie and Lewis 2003).

In a quantitative study, to establish validity means to ensure that both the measurement or instrument used is valid, and the design of the study is also valid (Giddings and Grant 2009). In this research, multiple strategies including cognitive interviews, multiple stage expert reviews, and pre-testing were used to validate the questionnaire designed in Phase 3. The relevance of the findings was also enhanced by the use of a sampling technique which ensured that the findings were as generalizable to the population as far as possible (see section 8.3.2). Similarly, in Study A, GPs were recruited first using probability sampling, and because of difficulties with recruiting, snowball sampling was used as a last resort (see section 5.2.3). In Study B, the aim was to obtain viewpoints from people of all ages; therefore a purposive sample was used.

In a qualitative study, the focus generally is not on sample size but rather on sample adequacy because generalizability is not what one is aiming for. Hence, the adequacy of sampling is usually justified by reaching 'saturation' (Bowen 2008) and is used by researchers as an indication of quality (Guest 2006). Thematic saturation (and not theoretical saturation) was used for Studies A and B in this research. This meant that data was collected until there were fewer surprises in the data, and no more patterns or themes emerged from the data (O'Reilly and Parker 2012).

Using subtle realism as the ontological position in this research meant that the researcher strived to be as neutral and objective as far as possible when collecting, analysing, interpreting and presenting qualitative data, and took particular care not to influence the participants in any way. For example, whilst recruiting participants for Studies A and B, the researcher ensured that any email correspondence with participants did not contain an email signature of the researcher that included her twitter account or her website (which would have illustrated her professional use of social media), because of the possibility that it may influence the decision of participants to criticise social media in the interviews.

Taking a subtle realist approach also means to acknowledge that although one may work hard to remain objective, this is not always possible, and biases may creep into research practice. This is why the researcher's reflexivity about her own background is relevant, so that the objectivity of a piece of research can be scrutinised (Ritchie and Lewis 2003). Although the researcher had a technological background, the researcher was not led by that alone. The topic guides and coding frames used in both Studies A and B were also checked by the researcher's supervisors (who had divergent personal opinions of the topic area) to ensure that there was no bias. Similarly, the questionnaire used in Study C was also evaluated in Phase 3 using multiple validation methods to ensure there was no bias or errors.

In all phases of this research, there was a clear audit trail of decision making processes, both in terms of the research question and design; as well as the interpretation from raw data, because this can help ascertain the reliability of the research (Giddings and Grant 2009; Mays and Pope 2000). For example, interpretations and findings were always supported by participant data, and where a coding frame was used (for example in Study A), a copy of it was provided. Similarly, in Phase 4 of this research – where the questionnaire was developed and validated –

tables with changes and amendments were clearly provided to illustrate changes made after each stage of the evaluation and validation process (see Appendix E).

Another strategy that could be used to increase the validity of research is triangulation (Giddings and Grant 2009; Ritchie and Lewis 2003). This is where more than one method or type of data collection is used to ensure there is internal agreement and the findings are comprehensive. This was used in Study C (Phase 4), where open ended questions were used to explain responses to closed questions.

4.5 PRACTICAL CONSIDERATIONS

Ethics and research governance – Ethical approval was sought for Phase 1 (Study A) from the Biomedical Research Ethics Committee at the University of Warwick in June 2012 (#223-07-2012), and from the NHS Cambridgeshire Primary Care Trust (#L011196). The latter was not required, as later confirmed by the National Institute for Health Research (UK), because the GPs were being approached through public databases of lists and were providing feedback about general attitudes, both of which were not related to their contract for NHS services.

Ethical approval for Phases 2, 3, and 4 was sought in May 2015 from the Biomedical & Scientific Research Ethics Committee at the University of Warwick (#REGO-2015-1472). In December 2015, an amendment to Phase 4 was approved (#REGO-2015-1472 AM01) to allow Ipsos MORI interviewers to conduct the face-to-face interviews on the researcher's behalf. All copies of ethical approvals are in Appendix B.

In Phases 1-3, all participants were sent a participant information sheet beforehand either through email, in the post or in person, and this contained the aims of the study amongst other things. Informed consent was obtained from all participants before the start of the interview (see Appendix B for copy of consent sheet used). In Phase 4, a participant information sheet was provided before the questions were asked, and verbal consent was taken from all participants. There was no physical or psychological risk to participants involved in all phases of this research. All participants were informed that participation would be on a voluntary basis. Upon wishing to participate, any questions they did not want to answer could be left unanswered, and they were also free to withdraw from the study at any time.

Questionnaire mode and sampling – The aim of Study C was to get a representative view of the public in England. In Phase 3 of the research, a pragmatic decision had to be made as to which questionnaire mode would be most appropriate, using a sampling method and size that would produce a representative sample, and be feasible within the budget constraints. Detailed information about the decision making process as well as the modes that were considered are explained in section 7.5. In summary, the strongest mode available within the budget constraints was selected. This was a face-to-face questionnaire using the Computer Assisted Personal Interviewing approach, with 844 members of the public selected using random location quota sampling.

Cost – GPs were given £80 to participate in Study A. This is what GPs normally receive for participating in research, and was confirmed by the Clinical Research Network, Research Management and Guidance Office and the research support services manager at the NHS Cambridgeshire Primary Care Trust (PCT) in 2012. Payment was given directly from the university to the GPs, as advised by the NHS Cambridgeshire PCT.

The remaining studies and phases used volunteer participants, so there was no cost of paying participants. In Phase 4, Ipsos MORI were hired to conduct the face-to-face questionnaires with the public, because it was not feasible for the researcher to conduct 844 public interviews across England, using a random location quota sampling method. Ipsos MORI was paid for this service, although the participants were volunteers. All costs were covered by funding from the Engineering and Physical Sciences Research Council under the Participation in Healthcare Environment Engineering Programme (#EP/H022031/1).

4.6 SUMMARY

This chapter introduced the overall research approach and methodology, and explained why a mixed methods multi-phase research was best suited to address the research question and objectives. Study A (Phase 1) and Study B (Phase 2) used a qualitative approach to describe and explain GPs' and patients' views towards OPF. This led to the development and validation of a population questionnaire in Phase 3, which was used in Study C (Phase 4) – a cross-sectional study – to explore patients' views on OPF. The mixed methods approach allowed a relatively new phenomenon,

OPF, to be explored from two different perspectives, which resulted in a more comprehensive understanding of OPF, and more robust recommendations and guidelines for OPF website providers, GPs and GP practices.

CHAPTER 5 - STUDY A (PHASE 1): EXPLORING GPS' AWARENESS, USAGE AND ATTITUDES TOWARDS ONLINE PATIENT FEEDBACK (OPF)

5.1 INTRODUCTION AND AIM

There is very little research that explores healthcare professionals' attitudes towards OPF websites. Therefore, the aim of this study[5] was to explore GPs' awareness, usage and attitudes towards OPF websites in England. This included exploring:

- how aware GPs are of OPF websites;
- how GPs feel about the transparent nature of OPF websites;
- the impact of OPF on GPs' emotions;
- whether OPF is useful to GPs for quality improvement.

5.2 METHODS

5.2.1 Data collection

As very little is known about GPs' perceptions of OPF, there was a need for in-depth exploration to capture attitudinal and experiential data, and therefore, a qualitative approach using semi-structured interviews was best suited. A topic guide was developed following the guidance suggested by Bryman (2008), Matthews and Ross (2010), and Tracy (2012) (see Appendix C for a copy of the topic guide). A literature review was used as a basis for the topic guide, as well as information from discussions with key stakeholders, such as the main lead at one of the OPF website providers in the UK, and four GPs. Further issues raised by participants during the interviews were also pursued, and participants were encouraged to draw on experiences to illuminate their responses.

Three Vignettes were developed (see Appendix C) following the guidance of Barter and Renold (2000) and were used as prompts if the participant had not seen an OPF website before. The vignettes contained a screenshot of a section of positive feedback left on NHS Choices, a screenshot of negative feedback left on NHS Choices, and a

[5] The material presented in this chapter has been published in Patel et al. (2015) and Patel et al. (2017)

screenshot of feedback left for a GP on iwantgreatcare.org. They were randomly selected from their respective websites in April 2012, and all identifiable information was blacked out.

5.2.2 Piloting the topic guide and interview

The topic guide was piloted on a professional acquaintance, after which the wording on a few questions was modified. Due to budget constraints, it was not possible to pilot the topic guide with a GP. A few questions in the guide were modified for the first six interviews, after which the topic guide remained the same, and is the version that is in Appendix C. The modification to the few questions consisted of either changing the wording of the questions, or the position of the questions in the guide, because the sentences were either too long to understand or were better suited in a different section of the topic guide.

5.2.3 Sampling and recruitment

An initial review of the literature found that it can be difficult to recruit GPs to research studies. Therefore the OvidSP database, Google Scholar, the Family Practice Journal, and Google were systematically searched to find attitude-based interview studies conducted with GPs in the UK, published after the year 2000. Seven studies were found, all of which mentioned how many GPs were interviewed in the study. However, only one study by Gott et al. (2004) described the key factors involved in the recruitment of GPs: i) the recruitment strategy (postal letters), ii) the length of the interview (one hour), iii) the reimbursement of time (at locum rate), and iv) the response rate (34%).

The length of the interview, recruitment strategies and response rates varied in the other studies. For example, in a study conducted by Curnock et al. (2012), a postal invitation was sent to GPs inviting them to a one hour interview, and this received an initial response rate of 7% (financial remuneration was not mentioned). Butler et al. (1998) had a much more successful response rate at 68%. They contacted GPs by telephone but interviewed them for only 10-35 minutes (again financial remuneration was not mentioned). There was a similar response rate in another study by Prosser (2003) where GPs were invited to participate by letter and followed-up with a phone call (resulting in a 73% participation rate). Again, there was no mention of the length

of interview or whether they were offered remuneration for their time. Corbett et al. (2009) recruited 10 GPs to participate in their study, from which two were interviewed face-to-face and eight by telephone for 15 and 30 minutes, but they do not mention how many were approached. Rogers (2002) recruited 21 GPs to his interview-based study but also does not mention how many GPs were approached, nor the recruitment strategy used or the length of the interview.

A probability sampling approach was therefore employed initially to ensure a wide range of characteristics of participants, as recommended by Bryman (2008). This meant that the initial plan was to approach around 20-25 GPs based at practices in Cambridgeshire through postal methods, with a follow-up phone call if needed. However, despite using various strategies (all described in Table 5-1), only 6 GP participants were recruited using probability sampling. Therefore, due to the limited response rate and the difficulties with recruiting sufficient GPs for this study using probability sampling, snowball sampling was used as a last resort. 14 further GPs were recruited this way using various approaches (detailed in Table 5-1) from Cambridgeshire, London and the North West of England. A detailed explanation of the challenges and approaches used for recruitment of GPs in this study has been reported in a peer-reviewed case-study published in SAGE Research Methods (Patel et al. 2017).

Table 5-1: Recruitment strategies and number of GPs recruited for this study

RECRUITMENT STRATEGY	NUMBER OF GPs RECRUITED
Probability sampling	
Direct invitation to GP *(postal invitations were sent to 25 practices in Cambridgeshire, which were then followed up by phone calls; and one PCRN (primary care research network) sent a letter on our behalf inviting and promoting the study to research active GPs and practices in Coventry)*	**1**
Invitation through practice managers *(phone calls were made to 25 GP practice managers in Cambridge and a follow up email was also sent; 13 further practices were then contacted through phone and then fax)*	**2**
Promoting study in email-based GP newsletters *(The study was promoted in the following GP newsletters: Cambridgeshire NHS Newsletter; Lewisham Weekly Newsletter; Lambeth PCT newsletter; South NHS North West London Newsletter; Participate Autumn Magazine)*	**3**
Snowball sampling	
Email to acquaintances with potential GP contacts	**1**
Twitter call out to acquaintances with potential GP contacts	**0**
GPs emailing their GP acquaintances	**5**
Medical doctors phone calling their GP acquaintances	**8**
Total	**20**

In total, twenty GPs were interviewed for this study, because at this point thematic saturation had been reached. This is the point at which there were fewer surprises in the data, and no more new major descriptive themes emerged from the final two sets of interview data (O'Reilly and Parker 2012).

5.2.4 Study interviews and participants

The interviews took place between the period of Aug 2012 and Jan 2013, and were conducted at the location that was most convenient to the participant, with a preference given to the GP practice where the GP worked. However, some GPs preferred to be interviewed at their home outside of working hours, and one locum GP was interviewed at a private meeting room.

All participants were sent an invitation letter and the participant information sheet beforehand (see Appendix C) either via email or in the post. Informed consent was taken from all participants before the start of the interview. Interviews were digitally recorded using the *iTalk* iPhone app as well as an Olympus digital voice recorder. The interviews ranged from 32 to 82 minutes in duration, with 50 minutes being the mean average. Vignettes were used as prompts when needed.

The descriptive characteristics of the 20 participants interviewed are shown in Table 5-2. Although 60% of the GPs interviewed were between the ages of 30-34, they varied in their duration of experience as GP, type of GP and gender.

Table 5-2: Demographics and practice characteristics of participants (n=20)

BASELINE CHARACTERISTIC	FREQUENCY (%)
Age	
25-29	1 (5%)
30-34	12 (60%)
35-39	3 (15%)
40-44	1 (5%)
45-49	1 (5%)
50-54	1 (5%)
55-59	1 (5%)
Gender	
Male	12 (60%)
Female	8 (40%)
Type of GP	
Salaried	6 (30%)
Partner	7 (35%)
Senior Partner	2 (10%)
Lead	1 (5%)
Locum	4 (20%)
Years practicing as GP	
1-5	14 (70%)
6-10	2 (10%)
11-15	1 (5%)
16-19	1 (5%)
20+	2 (10%)
Location of GP	
Northwest of England	9 (45%)
Cambridgeshire	6 (30%)
London	5 (25%)

5.2.5 Data preparation and analysis

The Framework Method was selected as the principal data analysis method. It is a form of thematic analysis developed in the 1980s by researchers at the NatCen Social Research Institute and has been used widely since then, both in policy research and other areas (Dixon-Woods 2011; Ritchie et al. 2013; Smith and Firth 2011). As an analytic tool which supports the key steps in the data management process of semi-structured interviews, the approach is well suited to both descriptive and/or explanatory research, because it helps to identify commonalities and differences in the data, and within the data (Gale et al. 2013). Its distinctive feature is the visually straightforward matrix output: rows (cases), columns (codes) and 'cells' of summarised data, which systematically reduce the data and allow the researcher to read and analyse across the data thematically whilst keeping the individual cases or interviews as a whole to see. It is for these reasons it is especially suited to large data (Gale et al. 2013; Ritchie et al. 2013). This is why it was chosen as the appropriate method to help manage and interpret the data within this study.

Before moving on to the interpretive stage of the analysis, the Framework Method helps to manage and sort the data with clear steps. However, it is appreciated that the steps may not always be linear and may be adapted within the context of each study (Ritchie et al. 2013). The steps used for this study are as follows, and are an amalgamation of the steps suggested by Ritchie et al. (2013) and Gale et al. (2013):

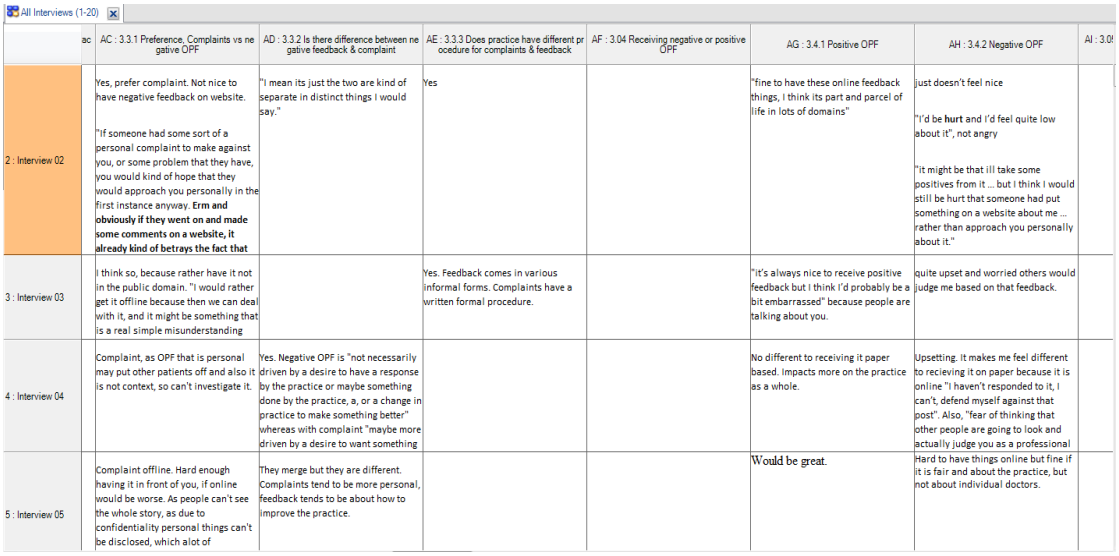
1. Transcribing the data
2. Familiarising with the data
3. Constructing an initial thematic framework
4. Coding and applying the framework
5. Charting the data into a framework matrix
6. Interpreting the data

As the first step towards a formal analysis, interviews were transcribed verbatim into Microsoft Word using the assistance of Express Scribe software and the Dragon Naturally Speaking software. Each transcript was double checked for inaccuracies and typographies, as well as inaudible sections. The word count of the complete set of transcripts was just over 190,000 words.

Once the interviews were transcribed, they were imported into the NVivo software. The interview transcripts were read and the data topics and subjects of interest were identified. This then helped to form the initial thematic framework, which contained a set of emergent themes and subthemes (represented as 'codes' in NVivo and labelled with an appropriate number and description), derived from both the data and themes in the topic guide and from research questions and aims. The framework (represented as 'codes' in NVivo) was then applied to each interview, and the framework was refined constantly at this stage as the interviews were 'coded', with new themes and subthemes emerging.

Once these themes and subthemes were reviewed and finalised (see Appendix C for the complete thematic framework), the Framework function in NVivo (called 'Framework Matrices') was selected, which generated a Framework Matrix (see Figure 5-1 for an example). Each subtheme was allocated a column and the first column of the matrix contained the participant number. To reduce the size of data, the data was then summarised by subtheme, but where appropriate the original words of the participants were left to ensure meaning was not lost. The summarised version was

also linked to the original, so that in the later stages of the analysis, referring to the original when required would be easy to do.



All Interviews (1-20)

	ac	AC : 3.3.1 Preference, Complaints vs negative OPF	AD : 3.3.2 Is there difference between negative feedback & complaint	AE : 3.3.3 Does practice have different procedure for complaints & feedback	AF : 3.04 Receiving negative or positive OPF	AG : 3.4.1 Positive OPF	AH : 3.4.2 Negative OPF	AI : 3.0
2 : Interview 02		Yes, prefer complaint. Not nice to have negative feedback on website. "If someone had some sort of a personal complaint to make against you, or some problem that they have, you would kind of hope that they would approach you personally in the first instance anyway. **Erm and obviously if they went on and made some comments on a website, it already kind of betrays the fact that**	"I mean its just the two are kind of separate in distinct things I would say."	Yes		"fine to have these online feedback things, I think its part and parcel of life in lots of domains"	just doesn't feel nice "I'd be **hurt** and I'd feel quite low about it", not angry "it might be that ill take some positives from it ... but I think I would still be hurt that someone had put something on a website about me ... rather than approach you personally about it."	
3 : Interview 03		I think so, because rather have it not in the public domain. "I would rather get it offline because then we can deal with it, and it might be something that is a real simple misunderstanding		Yes. Feedback comes in various informal forms. Complaints have a written formal procedure.		"it's always nice to receive positive feedback but I think I'd probably be a bit embarrassed" because people are talking about you.	quite upset and worried others would judge me based on that feedback.	
4 : Interview 04		Complaint, as OPF that is personal may put other patients off and also it is not context, so can't investigate it.	Yes. Negative OPF is "not necessarily driven by a desire to have a response by the practice or maybe something done by the practice, a, or a change in practice to make something better" whereas with complaint "maybe more driven by a desire to want something			No different to receiving it paper based. Impacts more on the practice as a whole.	Upsetting. It makes me feel different to recieving it on paper because it is online "I haven't responded to it, I can't, defend myself against that post". Also, "fear of thinking that other people are going to look and actually judge you as a professional	
5 : Interview 05		Complaint offline. Hard enough having it in front of you, if online would be worse. As people can't see the whole story, as due to confidentiality personal things can't be disclosed, which alot of	They merge but they are different. Complaints tend to be more personal, feedback tends to be about how to improve the practice.			Would be great.	Hard to have things online but fine if it is fair and about the practice, but not about individual doctors.	

Figure 5-1: Example of a snapshot of a Framework Matrix (taken from this study)

Analytic memos were kept from the start to note down interesting ideas or themes, and these memos played a central role in the next more crucial stage of interpreting the data. The classification sheet in NVivo was used to classify some of the data (such as age, years practising), and typologies were created that were appropriate (see Appendix C). The matrix was then split and sliced into sub-matrices, and the descriptive themes or codes defined earlier were analysed individually (using second cycle coding, such as focused coding and pattern coding (Saldana 2009)), clustered where appropriate, and used to form more abstract categories and links between themes.

The process of each stage was noted down in memos within NVivo. Once the analysis within NVivo had been completed, the memos were then exported to Microsoft Word. Here the categories and themes were further refined (and some newly emerged) until explanations were formed (reference to the data in the Framework matrix and classification sheet in NVivo was constantly made at this stage when needed), and where appropriate, themes and sub-themes were generated. Explanations were presented diagrammatically where appropriate, and the initial thematic framework, the Framework Matrix and the thematic maps were also checked by the researchers' supervisors at their respective stages of development.

5.3 RESULTS & DISCUSSION

In this interview based study, participants were asked about their awareness, usage and attitudes (both positive and negative) towards OPF. The results of this study are divided into seven sections (see Figure 5-2 for a diagrammatic representation of the results section), and how they relate to existing literature is discussed too.

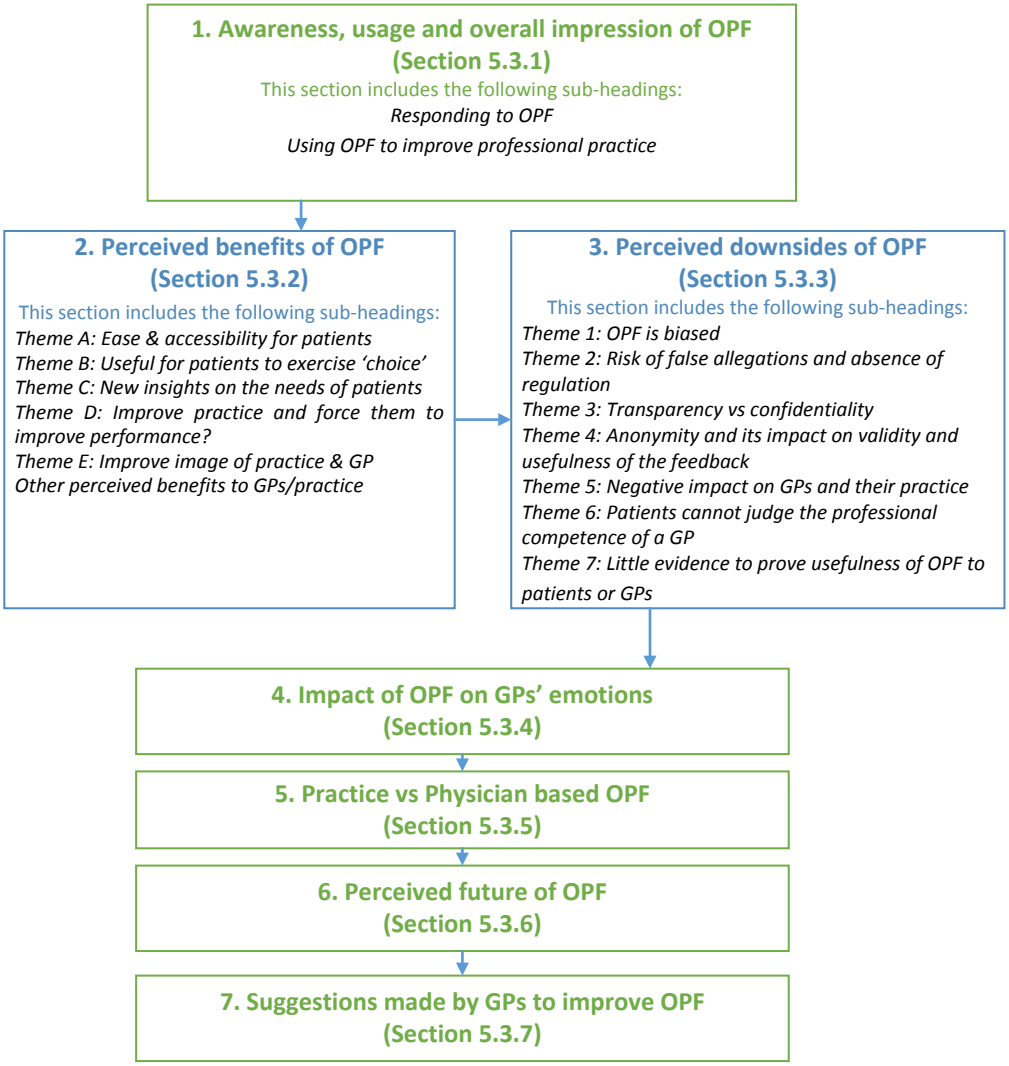


Figure 5-2: Outline of the results and discussion section of this chapter

5.3.1 Awareness, usage and overall impression of OPF

Three quarters of the GPs interviewed in this study were aware that patients can leave feedback for them or their practice on the NHS Choices website. However, only four GPs had direct experience with OPF, because their practice or GPs in their practice had received feedback online on the NHS Choices website. One of the GPs also

admitted he had received negative personal feedback online on the iwantgreatcare.org website.

The low usage of OPF websites by GPs in this study may explain why half of the participants mentioned an incorrect assumption about OPF websites, including that NHS Choices do not moderate comments, comments are only one sided anonymous (and not anonymous against GPs and healthcare professionals), and the most common one was that GPs cannot respond to comments left on the NHS Choices website. It is therefore not surprising that the majority of GPs interviewed (n=17) also did not currently consider OPF websites as a way of collecting feedback from patients.

However, twelve participants believed that patients do have a right to place feedback about their GP online, as long as the feedback was factually correct and on an appropriate website:

> *"Yes I think they have a right to give feedback, as long as they are not completely cra- [sic] I mean some people can be not completely sane." (P5)*

Five participants disagreed, suggesting that patients do not have the right to place feedback about their GPs online. Similarly, half of the participants (n=10) said they would not encourage their patients to give OPF, due to what they perceive to be problems with OPF, and a similar sentiment was expressed by McCartney (2009) and the BMA (Boffey 2011), who discouraged GPs from engaging with OPF. However, four participants (20%) said that they would encourage their patients to give feedback online, and two participants (10%) were unsure. A further four (20%) said they would only encourage those patients to give OPF who they know will give positive feedback:

> *"No, obviously, if somebody has had a good experience, you might encourage it [NHS Choices]. But also I think if somebody wants to make a complaint I would say you can write to the practice manager." (P7)*

The underlying reasons for this disagreement will be discussed in the forthcoming sections in this chapter.

Responding to OPF – There was also disagreement amongst participants whether GPs should respond to OPF. Seven participants said that GPs (or practice managers) should respond to critical feedback left online about them or their practice:

> *"Yeah, I think so. Because again... if a patient's going to leave feedback and there is something negative, it should be addressed – even if it's just by acknowledging it." (P6)*

The remaining thirteen participants disagreed, and argued that GPs should not respond to negative feedback left online about them, because it is not professional to do so, it could breach doctor-patient confidentiality, it is not a good use of their time, it could start a public *"slanging match" (P11)* and could make GPs look ridiculous:

> *"I'm not sure if that would be good use of my time ... patients often hold up their doctor as like a pillar of society, if you had the doctor trying to go, no no, I didn't say that, maybe it would make us look ridiculous." (P1)*

These findings are in-line with the suggestion made by Pasternak and Scherger (2009), McCartney (2009) and the BMA (Boffey 2011), all discouraging GPs from engaging with OPF due to the risk to doctor-patient confidentiality. Lagu and Lindenauer (2010) felt that it was impractical to expect busy clinicians or practice managers to reply to comments, especially in the USA, where there are over 30 doctor rating websites. However, more recently, an organisation that is mandated to represent and negotiate on behalf of GP practices in London – Londonwide LMCs (2015) – encouraged GPs and practices to reply to negative feedback left on the NHS Choices website, to show that they are listening, even if they do not agree with the comment. They are then encouraged to ask the moderator of the website to have the comment removed.

Lagu et al. (2013) analysed comments left for hospitals on the NHS Choices websites and found that 56% of comments had replies to them. However, they also found that 64% of those replies were not actually 'responsive', in that they did not describe specific changes the hospital had made or intended to make as a result of those comments, but rather were a more generic reply acknowledging receipt of the feedback. Further research is required to determine the extent to which GPs or GP practices are responding to feedback left on OPF websites, and how many of those replies are 'responsive'; and also patients' expectations of a response.

Using OPF to improve professional practice – One of the most pertinent questions is whether physicians and healthcare providers will use and can use OPF to improve their professional practice and the quality of care given to patients. Only one of the participants had received online feedback, but had used the feedback to

improve his practice. The rest had neither given nor received online feedback (as far as they were aware). Although there is a clear difference between the intention to make change and actual action, the majority of participants (16/18) said they would use OPF to change and improve their practice, as long as the feedback was true (and only two participants said they would not):

> *"Well, if something came to my attention that was a constructive comment, that seemed realistic and sensible, then yeah, I'm open to any kind of comments, however they come." (P9)*

Some participants raised concerns that due to the anonymous nature of OPF, they do not know who the feedback is left for and which consultation it refers to, and are therefore unable to either respond to OPF or use it (discussed in detail in section 5.3.3). One of the other ways that GPs could use OPF is to choose a provider. This is discussed in detail in section 5.3.2.

There is very little found in the literature about the use of OPF for quality improvement. Davidson et al. (2010) explored feedback on the Patient Opinion website and found that it was very difficult to get evidence on whether actual changes had been made as a result of OPF, and also feedback left offline. Furthermore, Boiko et al. (2014) observed that GP practice staff viewed results of patient experience surveys as a quality assurance mechanism rather than an improvement mechanism. Further research is required to explore whether OPF and even offline feedback is being used currently by GPs and practices across England for quality improvement and if so, how.

5.3.2 Perceived benefits of OPF

Participants were asked an open ended question about whether they can see any benefits to OPF. Participants appeared to be aware of and convinced of the benefits of OPF to the patient, but not entirely convinced of the benefits to themselves (only eight participants mentioned benefits to themselves, whereas eighteen mentioned benefits to the patient). The thirty two benefits raised by participants (twenty of which were unique) are illustrated in a thematic map (see Figure 5-3), and the five major themes (A-E) are explored in this section.

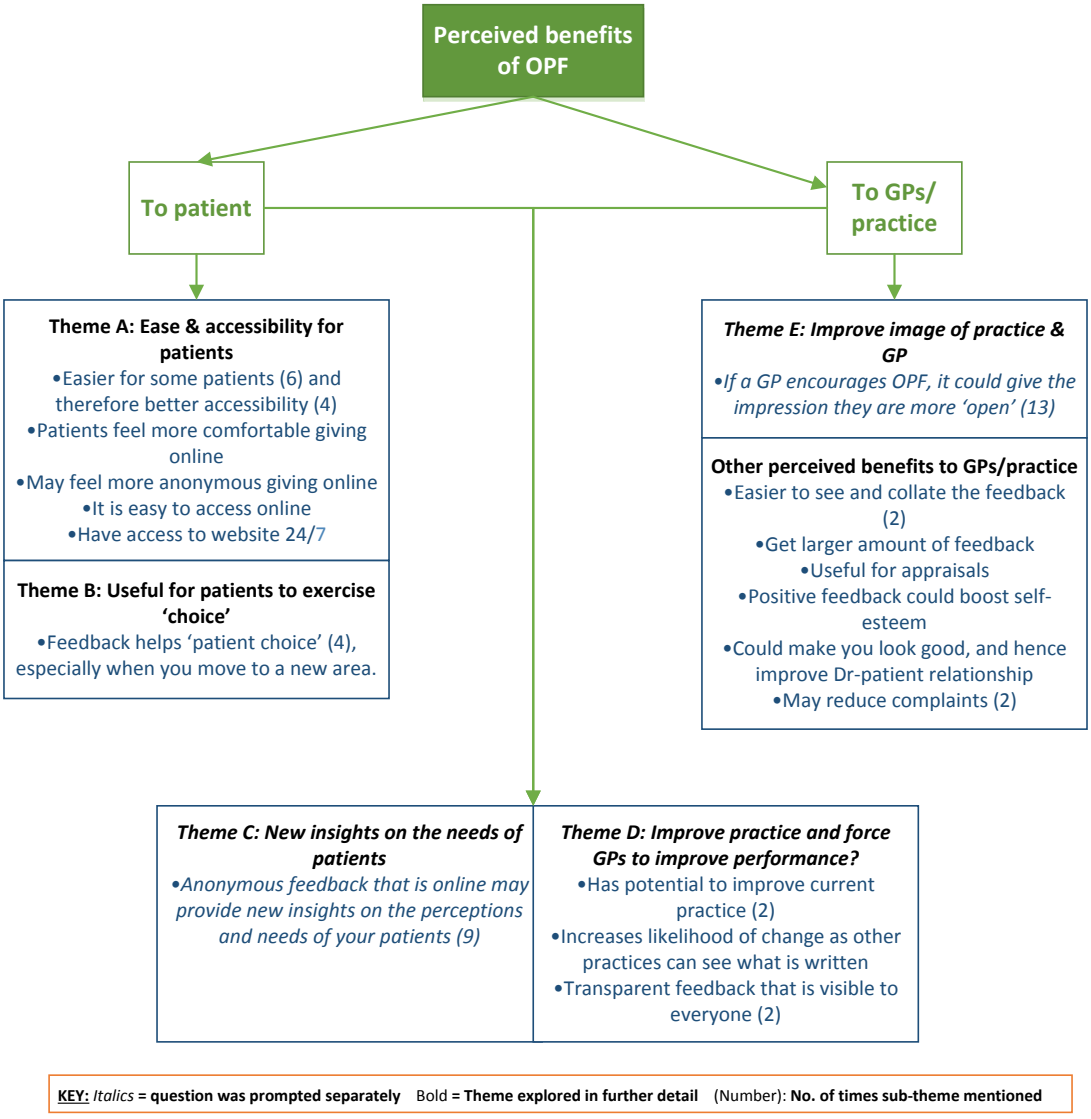


Figure 5-3: Thematic map illustrating the benefits of OPF, according to participants in this study

Theme A: Ease and accessibility for patients

All participants agreed that younger patients would find OPF websites easier to use than traditional paper-based methods of giving feedback, because of 24/7 access to the website, familiarity with websites, less time and effort required to give feedback, and the ability to share it with others. Findings from a study in Germany also suggested that younger people are more prone than older ones to use doctor rating websites (Terlutter et al. 2014). However, one participant argued that *"they [younger people] tend to be the ones who complain less, so that they may not need it so much" (P3).* As predicted, participants said that older patients would find paper-based methods of feedback easier to use than OPF websites, and they argued that older patients make up the majority of patients in some practices:

"You will never get anyone above the age of 65-70 on NHS websites, and that is about a third of our patients, maybe more" (P7).

Despite this, participants still recognised the other benefits of OPF websites for some patients, such as having access to the website 24/7, instead of being restricted to traditional satisfaction assessments, which are normally limited to a single encounter or time frame (López et al. 2012). Furthermore, as the feedback online is anonymous, a few participants felt that some of their patients would feel more comfortable giving it through this anonymous medium (anonymity is discussed in section 5.3.3). However, further research is required to ascertain whether these assumptions made by GPs about their patients is true, and the impact this may have on the future of OPF websites, and other feedback methods available in general practice.

Theme B: Useful for patients to exercise 'choice'

As discussed in Chapter 2, the patient choice agenda has both supporters and opponents (Dixon et al. 2010; Fotaki 2014; Powell 2015). These opposing views were also reflected among participants, with seven participants saying that OPF was not useful for patient choice at all because of the way the website collects and presents these reviews:

"My one experience in that one clinic doesn't form [the] basis [of] whether a hospital is good …. it's not going to help someone to choose necessarily because it is such a subjective thing." (P19)

A few others disagreed with the patient choice agenda itself:

"In principle I can see the value of having a sort of a trip advisor type website that gives information … the trouble is, the whole patient choice agenda … everyone was meant to have a choice about where they want to go, but in practice they haven't." (P9)

However, three participants said that it could help patients make a choice of which provider to see, and a further seven said it may be useful for that purpose but with severe limitations (such as bias, see section 5.3.3), and three participants were unsure.

Participants were then asked whether they would use OPF websites themselves as patients to decide which provider to use. Eight GPs said they would not use it for that purpose; however, six GPs said they would use it personally, especially if they were moving to a new area:

"I would consider if I was registering with a GP practice, moving to a new area, thinking yeah which practice would I register with, I'd go online and have a look at what's being said about the practice." (P2)

Whilst all the participants in this study were users of consumer rating websites (such as Trip Advisor and Amazon reviews), some participants were eager to highlight the difference between OPF and Trip Advisor, and the results did not appear to show a correlation between attitudes to rating websites like Trip Advisor and attitudes to OPF:

"I use it [rating websites like Amazon and Trip Advisor] a lot and rely on people's reviews a lot, which knowing you were coming, it made me reflect quite interestingly, that I have a great amount of faith in these reviews, but I have no faith at all in the health side reviews, it's an interesting conflict if it were, which I will find hard to explain." (P9)

To summarise, although some participants felt that OPF will enhance patient choice, the majority of the GPs interviewed in this study felt that OPF websites (as they currently are) are not useful for patient choice. The usefulness attached to OPF for patient choice by GPs is important, because if GPs believe that OPF is useful for patient choice, they may be more likely to use it, accept it and promote it to their patients.

Theme C: New insights on the needs of patients

Advocates of OPF have argued that anonymous feedback left online by patients will provide new insights on the needs and perceptions of patients (Bacon 2009; Carvel 2008; López et al. 2012). Almost half of the participants in this study agreed with that argument:

"Yes it might do … the population of patients who are a bit reluctant to making complaints or they don't want to be identified… I think that might be a good way for people to voice their opinion." (P4)

However, the other half were sceptical, with those disagreeing suggesting things like anonymous is not mutually exclusive with online. Others said it could potentially provide new insights, but again it would depend on the validity of the data:

"Possibly, but the usefulness and the truthfulness of data would have to be scrutinised." (P17)

Theme D: Improve practice and force them to improve performance?

Two participants expressed that OPF had the potential to improve current practice, and believed that not only could it improve the doctor-patient relationship but that positive feedback could boost the self-esteem of GPs too. A few participants felt that due to the transparent nature of the feedback, change was more likely as other practices can see what is written. Adams (2011) found that some OPF websites were created under the premise that publishing comments online would make hospitals more transparent about their practices.

Similarly, Ben Bradshaw, a former British Minister for Health, argued that OPF will force doctors to improve their performance and bedside manner out of fear that patients may post online about them (Carvel 2008; Symons 2008). Participants were asked whether they believed it would 'force' GPs to improve performance. Four participants felt that it would because they would feel under pressure to perform better:

"It's like being on CCTV … it may improve the bedside manner, and that if they are aware, yes. At the end of it I think there will probably be better patient care." (P10)

Seven participants felt that it could possibly force them to improve their performance, but not necessarily in a good way, as it would make them practice more defensively. However, the remaining eight felt that it would not force GPs to improve performance, because GPs will not take OPF seriously as it is not formal feedback. This appears to be in-line with findings from Davidson et al. (2010) who found that just because stories about the quality of services appeared in the public domain and affected an organisation's reputation, this did not mean that they would automatically become drivers for improvement in the NHS. One participant suggested that rather than force GPs to improve performance, it would make them insecure and anxious:

"My worry is that it might make the person – other doctors [sic] performing well – to become more anxious, insecure about how he's performing anyway." (P16)

These findings suggest that some GPs believe that OPF will not only impact a GP negatively but make GPs practice more defensively, and this is discussed in further detail in section 5.3.3.

Theme E: Improve image of practice and GP

More than half of the participants agreed that if they were to encourage their patients to give feedback online, they would be looked upon more favourably by patients, particularly as being more 'open':

> *"Would create an impression ... I suppose it's the idea you've got nothing to hide, you're more open, more encouraging." (P9)*

Three participants were unsure, and the remaining three disagreed saying that *"we have [an] elderly population anyways," (P20)* so it would make no difference.

Other perceived benefits to GPs/practice

Participants also mentioned other perceived benefits of OPF for GPs or practices. A few participants expressed that collecting feedback online is easier, because it is easier to manage than traditional paper methods of collecting patient feedback, and this also means it is easier to get a larger amount of patient feedback. This has also been suggested by the report from The Evidence Centre at The Health Foundation (Silva 2013), although it highlights that one needs to be aware that only web users would use OPF websites to give feedback. One participant also mentioned that because it is much easier to collect patient feedback online, it could be useful to GPs for their appraisals too.

5.3.3 Perceived downsides of OPF

In this study, 56 individual concerns were raised by GPs (31 of which were unique) when asked the open ended question: Do you have any concerns about OPF? Other concerns raised about OPF during the interview were also included in the analysis. Figure 5-4 is a thematic map which shows a summary of the concerns raised by participants, and the seven major themes related to perceived downsides of OPF are discussed in this section.

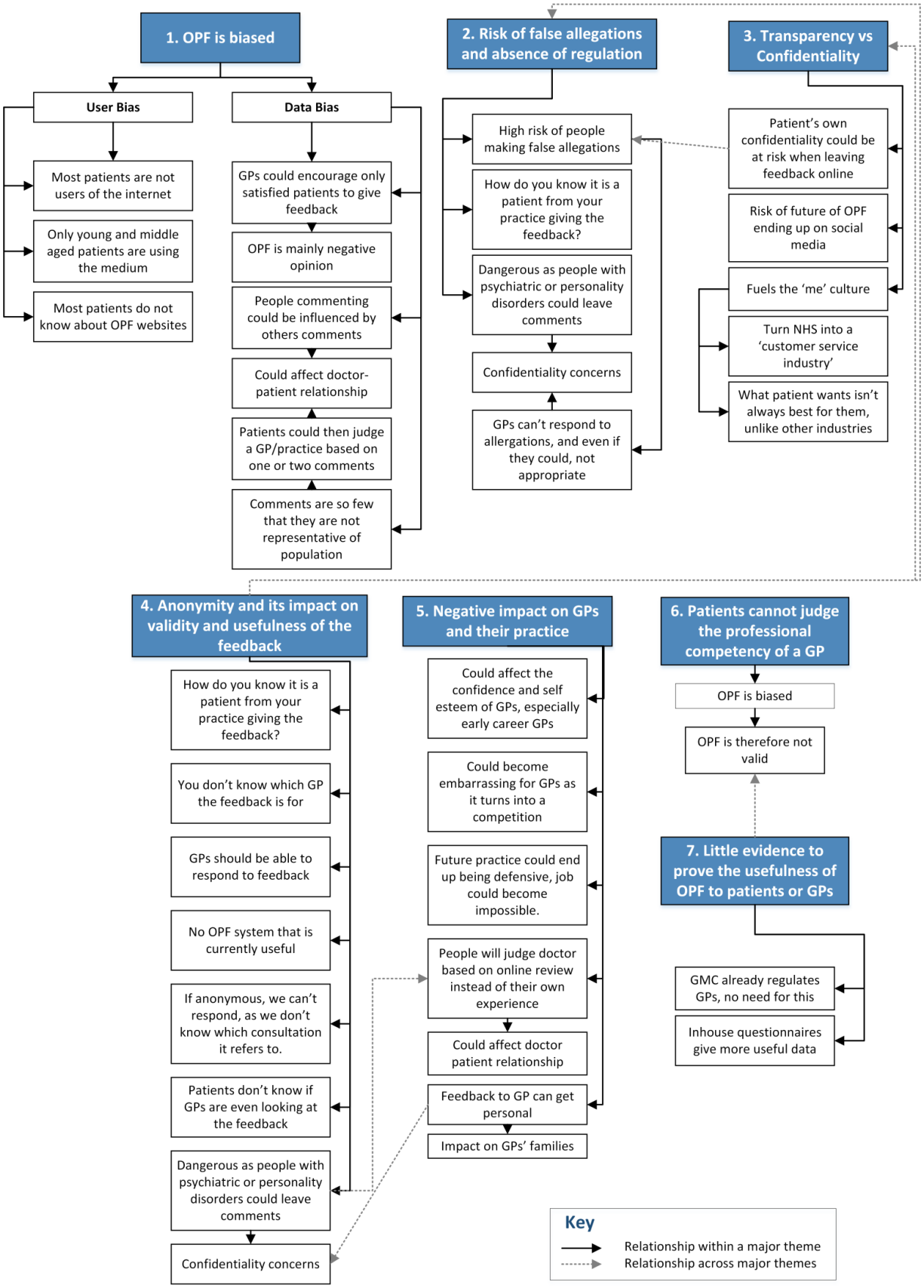


Figure 5-4: A thematic map illustrating the downsides of OPF, according to GP participants in this study

Theme 1: OPF is biased

User Bias – Most participants were concerned that it is only young and middle aged patients who are leaving feedback on OPF websites. Some participants commented that the majority of their patients were in fact elderly, who were certainly not using this medium, which according to them indicates that the feedback and ratings that are online are not representative of the overall experience of their patients, and therefore question its validity and usefulness:

> *"You are getting your opinions from again, one particular sector of the community … their perceptions, their understanding and attitudes are different to the rest of the population …. You have to use it with a bit of scrutiny there, in terms of interpreting the data, how do you put that in practice – if you were to put in any changes?" (P10)*

One participant felt that there was not enough publicity about the NHS feedback website and many patients do not even know about the website.

The concern of potential bias due to the age of patients using OPF (in favour of younger patients) has also been raised in the literature by some (Lagu and Lindenauer 2010; McCartney 2009; Rozenblum and Bates 2013; Tritter and McCallum 2006), and some studies appear to support it (Bidmon et al. 2014; Galizzi et al. 2012; Greaves et al. 2012b; Terlutter et al. 2014). It could be argued that even patient satisfaction results that are offline are influenced by age, education, and health status (Hekkert et al. 2009). However, a study conducted on data from the NHS Choices website in England by Greaves et al. (2012b) found that practices that served younger patients, more urban and less deprived communities were more likely to be rated, and this they believe suggests that individual characteristics of patients may have a role in influencing usage of OPF websites. This was also explored by Galizzi et al. (2012), who found that amongst other things, increasing age was a significant negative predictor of doctor rating website awareness in the UK. Interestingly, they also found that although there may be age-related access barriers, intention to use them was the same across all ages. Due to the limitations of their study (including a small sample size), further research is required to corroborate these findings.

Greaves et al. (2012a) argue that although there may be risks in using ratings from a small group of self-selecting patients, according to them it is outweighed by its positives, mainly that OPF is low cost and has the ability to detect episodes of poor

care that a traditional survey may miss. However, as some participants highlighted in this study, this does not address the question of whether a rating of a particular GP or GP practice can truly be representative, valid and fair if only the younger and middle-aged patients are leaving feedback? This is especially crucial for those practices and GPs that serve a largely elderly population.

OPF is mainly negative opinion – One of the oft repeated concerns raised by a quarter of participants was that OPF constitutes mainly negative opinion, and is and will become a channel for disgruntled patients:

> *"There's a bias towards putting negative feedback, if they've had a good experience, non-outstanding one but an adequate one, they have no complaints but their needs are made, they are unlikely to go on and post positive feedback" (P13)*

Other participants argued that it only takes one negative feedback to harm a GP's reputation:

> *"One unfortunate comment or bit of a negative feedback, which may be taken well out of context, can harm your reputation." (P16)*

The sentiment that OPF is mainly negative has been raised in opinion articles (Boffey 2011; McCartney 2009) and literature too (Gao et al. 2012; Merrell et al. 2013), but has been counteracted by the argument that many studies (including Alemi et al. 2012; Black et al. 2009; Detz et al. 2013; Emmert et al. 2014; Gao et al. 2012; Greaves et al. 2012b; Kadry et al. 2011; Lagu et al. 2013, 2010; López et al. 2012) have found that the majority of feedback left on doctor rating websites is in fact positive (Verhoef et al. 2014). However, Greaves et al. (2012b) found that the recommendation level of GP and practices in England for the same period was 64% online, and 82% in patient surveys. This, they suggest, does indicate that there may be a selection bias in OPF towards less satisfied patients in comparison to when patients are selected randomly, and this appears to indicate that the concerns raised by participants in this study may in fact be valid.

Furthermore, Merrell et al. (2013) argue that the abundance of positive reviews cannot negate the impact of negative ones, as negative ones, however few, can have long lasting ramifications, as some GPs in this study highlighted too. This is further supported by findings from a study by Hanauer et al. (2014b) who found that parents who are exposed to a positive recommendation of a physician from a neighbour are

less likely to choose that physician for their child if they were then exposed to negative reviews about that same physician online. However, Adams (2011) found that patient reviews online are not always inherently positive or negative, rather they contain a mixture of positive and negative comments, as well as references to and comparisons with previous healthcare experiences.

OPF is too small in number – A few participants (n=3) raised concerns that where feedback is left for a GP or a GP practice on websites, it is too small in number and therefore it is not representative of their record of performance:

> *"it's a small number of comments, we've had two [online reviews] out of a population of 12,000 [on the NHS Choices website], I don't think that would be representative enough for a potential patient to go on and go, 'alright ok they've got 50% bad comments, right I'm not registering there' (laughs)." (P2)*

GPs were therefore concerned that patients could judge a practice or a GP based on a very small number of reviews (and make an invalid 'choice'), and this could also affect the doctor-patient relationship.

The assertion that OPF is too small in number appears to be supported by a study on the NHS Choices feedback website which found that only 61% of GP practices in England had been reviewed and the number of ratings left per practice was variable with a mean average of only two ratings per practice (Greaves et al. 2012b). However, this study by Greaves et al. (2012b) explored data from over 5 years ago (between the period of Oct 2009 and Dec 2010) and more up to date analysis of such websites is required to truly understand the current state, as usage may have changed. Despite this, taking into account that reviews on the NHS website only correspond to 0.005% of all GP consultations (Greaves et al. 2012b), and that studies from the USA (Ellimoottil et al. 2013; Gao et al. 2012; Lagu et al. 2010; Mostaghimi et al. 2010), Germany (Emmert et al. 2009; Emmert and Meier 2013; Strech and Reimann 2012) and Australia (Atkinson 2014) all indicate that less than 30% of physicians have been rated (and even those that have been rated, have on average less than 4 ratings each), the assertions raised by the participants in this study may in fact be true and valid, and need to be addressed by OPF website providers.

Strech (2011) suggests that the solution to this may be that ratings should not be made available until they reach a certain baseline number such as 5-10. Although

individual pieces of feedback could be displayed before a baseline number is reached, the overall star rating for example should not be shown until there are a reasonable number of ratings left for a practice or GP. If the NHS and other OPF website providers want GPs to take these reviews seriously and for the ratings per practice to be 'valid' and representative (so that patients can make an accurate 'choice'), it needs to do more to get patients to give reviews (see Chapter 9 for a list of recommendations for OPF providers based on findings from this study). However, although the overall rating may not be representative of the quality of care provided by GPs, this does not mean that the individual patient feedback left may not be useful to GPs and practices in order to make changes and identify opportunities for improvement. This suggests that even though some OPF website providers may choose not to publish reviews until a certain baseline has been reached, the reviews could be sent to GPs and practices to review and use for improvement.

The limited number of online reviews for GPs and practices may be partly explained by one participant's comment that "*patients do not even know about OPF" (P20)*. This appears to be supported by a study that found that only 15% of the 200 participants in one borough of London were aware of the existence of OPF websites (Galizzi et al. 2012). However, this study was conducted almost three years ago, and the awareness of OPF amongst Londoners may have grown since then. There is also little evidence on the extent to which the NHS Choices feedback website is known and used by patients in the UK. In the USA and Germany, recent studies found that around a quarter of respondents had used a doctor rating website (Emmert et al. 2013a; Terlutter et al. 2014). This may be partly due to the higher usage and popularity of private healthcare in both USA and Germany.

Reviews could be 'gamed' – Some participants (n=5) were concerned that reviews could be manipulated, and that some GPs could encourage only satisfied patients to give feedback, which again would add bias to the data. Moreover, four of the participants from this study admitted they would only encourage those patients who they know will give positive feedback to leave feedback online:

> *"No, obviously, if somebody has had a good experience, you might encourage it [leave feedback on NHS Choices]. But also I think if somebody wants to make a complaint I would say you can write to the practice manager … I may not actively promote it [giving feedback on NHS Choices]." (P7)*

This concern is similar to concerns raised in the literature that ratings could be 'gamed' by organisations or individuals and people could leave fake or multiple entries (Greaves et al. 2012b; Lagu and Lindenauer 2010; Segal 2009). Lagu et al. (2010) analysed feedback on review websites in the USA and found several reviews which they felt had been written by the physician him/herself because they contained information only the physician would know. In another study, Kadry et al. (2011) found some reviews which they believe were acts of sabotage from competing providers.

Theme 2: Risk of false allegations and absence of regulation

Half of the participants felt that there was a very high risk of patients leaving false allegations about them or the practice on OPF websites. Furthermore, a quarter of participants felt that the owners of such websites (such as the NHS Choices feedback site) were not regulating feedback left on these websites, nor removing malicious or factually incorrect comments from patients. Participants were particularly concerned that their patients with psychiatric or personality disorders could leave factually incorrect or malicious comments about them, and harm their reputation:

> *"You will have everyone, including people with severe psychiatric illness [leaving feedback on OPF websites] ... so I think it's [OPF] potentially quite [a] dangerous tool." (P19)*

Furthermore, a few participants (n=3) felt that even if GPs could respond online to such allegations, it would not be appropriate for them to respond online. Concerns about slander have also been raised by critics of OPF websites, mainly physician representatives, such as the BMA (Todd 2012). However, NHS Choices in England claim to have a strict set of regulations that they use to protect physicians and hospitals from content that may damage their reputation (NHS Choices 2015). Despite the NHS Choices promising that all 'inflammatory remarks' are removed, it is unknown how this is put into practice and to what extent, and also what constitutes 'inflammatory'. Owners of such websites need to make this clear to their users (Strech 2011). Furthermore, a few participants in this study remarked that although the NHS Choices website may anonymise the doctor, it was easy for GPs and the public to work out which GP or staff member the comment was directed to, and therefore the website does not really give GPs the anonymity and protection it claims to.

Theme 3: Transparency vs confidentiality

The transparent nature of OPF websites is what has made it so attractive to patients and health policy makers, as the understanding is that reviews left online will increase transparency of care and improve the quality of care (Adams 2011; Kadry et al. 2011). Eight participants agreed that patient reviews left online will seemingly help to increase transparency of care and improve the quality of care, and they were not concerned about the feedback being online, as long as there was a 'proper system' in place for OPF:

> *"It worries me if it's [OPF] not a proper system." (P18)*

By 'proper system', participants meant that the website was well regulated and validated. The website could verify for example that the patient leaving the feedback was an actual patient of that particular GP, or that the patient did not have a malicious agenda.

However, eight participants were concerned about the website being "too open" *(P11)* and in public due to the possibility of people making false allegations, and its damaging impact on the reputation and career of a GP, and a GP's own personal confidentiality:

> *"If it's [feedback] in public, particularly if I felt it was untrue … if you got y'know someone made an allegation … if that happened to a doctor it could destroy their career, and their self-esteem, and I just think that's not fair on doctors." (P1)*

This concern was also raised by McCartney (2009) and physician representatives in England (Coombes 2009). However, another participant felt that the harm to reputation was inflicted offline too, so it made no difference whether it was online or offline. Others remarked that being online was 'too public' and hundreds and thousands of people could have access to it. Some physicians have therefore gone as far as getting a court order to remove a review, according to Kadry et al. (2011), but the authors also believe it is very difficult to defend against online misinformation and defamation.

A few participants felt that these types of websites would fuel what they called the 'me' culture and turn the NHS into a 'customer service industry', and were concerned that in the future it could lead to patients thinking it is perfectly fine to leave

feedback about physicians on social media, where according to them, it is impossible to validate or regulate the feedback. Another participant went on to explain that particularly in healthcare, what a patient wants is not always what is best for them:

> *"There can be a difference certainly between what people need and what people want, and if people don't get what they want, often they can feedback negatively about that, even though actually the doctor or the medical provider or whatever who is looking after them, has done exactly the right thing." (P2)*

As well as worrying about the confidentiality of GPs themselves, a few participants were also concerned that the transparent nature of the feedback meant that a patient's own confidentiality may be at risk because they may feel the need to disclose personal health information about themselves on a public website. Some participants (n=3) were also concerned that GPs are unable to respond to patient reviews online due to the possibility of violating doctor-patient confidentiality, as they may need to disclose health information about the patient in their response.

Theme 4: Anonymity and its impact on validity and usefulness of the feedback

All participants (n=20) were aware that the feedback left on NHS Choices was left anonymously by patients. Some participants raised concerns that because the feedback was left anonymously, they would not know which consultation it referred to and could therefore not respond to the feedback, or make real use of it for improvement. Others (n=5) felt that the anonymous nature of the feedback meant they would not know if it was an actual patient from the practice that had left the feedback, and questioned whether such feedback is even valid:

> *"Again, if it is anonymous, then, with any feedback really, you really don't know, is it somebody from this practice, or somebody, well it could be anybody really leaving a feedback there [on OPF websites]." (P10)*

Participants were then asked specifically if the feedback would be more useful to them if it was not left anonymously. Seven participants said that it would be more useful to them if the feedback was left with the patient's real name so that they can then look up the consultation and see what went wrong:

> *"If you had their name there, you could obviously understand from where this is coming from, and then you can think about it or go back on it, and make ways of improving yourself during your consultation skills. But if it is very anonymous … out of seeing 40*

patients in a day, 200 in a week, which one are we talking about, in terms of who?" (P10)

This concern was also raised by McCartney (2009) who as a practicing GP felt that it was difficult, if not impossible for doctors to learn from anonymous comments, and thirteen healthcare professionals in a recent study also voiced similar concerns (Speed et al. 2016).

However, the remaining thirteen participants disagreed, commenting that it would not be fair on patients to give their real name, because according to them, it will affect the doctor-patient relationship and patients will not leave feedback online if they cannot leave it anonymously. One participant appeared to suggest a solution that patients should leave their NHS number when they leave feedback to verify that they are a patient registered at that particular practice. Another participant raised the question that despite patients not naming themselves when leaving feedback online, would patients really remain anonymous, as sometimes it was easy to identify a particular patient from an anonymous comment online. Further research is required to determine how patients feel about remaining anonymous and naming their GP when leaving feedback about their GP online, and whether remaining anonymous and naming their GP are key criteria for them to leave feedback on OPF websites.

Theme 5: Negative impact on GPs and their practice

As well as the threat of defamation discussed earlier and its impact on the reputation and career of GPs, two participants were also concerned that negative feedback online could affect the self-confidence and self-esteem of GPs, which would in turn affect their practice, especially those GPs who are early in their career:

"[OPF] will affect people in their early career a lot more, and could break their confidence and make them insular. Is that what you really want to be doing to your future doctors?" (P11)

Some participants felt that people will start judging GPs based on online reviews instead of their own experience, and this could affect not only the doctor-patient relationship, but also their practice. Furthermore, participants raised concerns that due to the possibility of negative reviews going online (whether true or false), future practice could end up being defensive, and it would be impossible to practice properly:

> *"I don't know how on earth we are going to have a decent relationship … doctors have become so defensive already … just to make sure they don't get things online, or do you want them to actually do right for you … give you good care in the right manner in the right time frame, in a manner which is satisfactory to, or do want them to just do things because they are so scared of litigation of online feedback." (P11)*

The concern about affecting practice, as well as harming doctors' psychological wellbeing was also found when academics recently explored doctors' experiences and perceptions of the complaints procedure in the UK (Bourne et al. 2016), and doctors called for the procedure to be reviewed.

Other GPs raised concerns that it could become embarrassing for them if their practice becomes public and turns into a 'competition', and this could impact patient care. One participant was particularly concerned about the negative impact OPF could have on her family:

> *"I suppose it's just the fact that something that's online … you think about your family and other people, close to you nearest and dearest, sort of looking at things and getting upset on your behalf as well." (P12)*

The concern about anonymous comments online harming their reputation was also raised by thirteen healthcare professionals in a recent study by Speed et al. (2016). Similarly, concern about the impact a negative review could have on GPs' families was also raised by McCartney (2009) in her opinion piece.

Theme 6: Patients cannot judge the professional competence of a GP

Some of the participants who were not in favour of OPF argued that the General Medical Council (GMC) already regulates them, so there is no need for patients to 'regulate' them online, and in fact how can patients judge whether a GP is competent or not?

> *"Can you really say a patient has that ability to say whether you are underperforming or not? … So the people that are doing appraisal and revalidation are also GPs, they know what you should be doing. I think they should police it, as opposed to patients." (P14)*

The concern of whether a patient can adequately judge quality of care was also raised by Lagu and Lindenauer (2010). In addition, others were concerned that physicians on these websites are rated not just on their professional skills but also as people (Strech 2011). Furthermore, a study by Adams (2011) found that the majority of

comments on Search Doctor (a Netherlands based doctor rating website) focused on the character of the physician and his/her ability to put the patient at ease, and this is how patients assessed the professional capability of a GP. In contrast, Detz et al. (2013) found that 41% of a sample of reviews from Rate MDs and Yelp (USA based rating websites) were about the technical competence of a physician. It would be useful to explore whether feedback left online from England matches these findings, and whether patients are aware that patient-led ratings may be based primarily on the bedside manner of a GP, according to some GPs in this study, and not necessarily on the clinical competence of a GP.

Theme 7: Little evidence to prove usefulness of OPF to patients or GPs

Two participants argued that there is no evidence currently to prove the usefulness of OPF to patients or GPs:

> *"I think some things with Government policy or in the NHS policy are brought in without having any evidence of benefit, sometimes people jump at the chance 'oh we will do this' and they don't think why." (P1)*

Although research into doctor rating websites has been steadily increasing over the past few years and studies conducted in the UK, USA, Germany, Netherlands and Australia are all adding to the growing literature (see Chapter 3), there is a huge gap in the literature. Further research is needed to determine for example whether patients believe OPF is 'useful' to them when giving feedback, or when choosing a healthcare provider.

Furthermore, a few other participants argued that existing methods of collecting patient feedback, such as in-house questionnaires are perfectly adequate and in fact give more useful data. However, when asked separately about offline feedback methods, more than half of the participants commented that they do not collect 'useful' data. This appears to be supported by findings from studies that show that GPs are sceptical about the value of patient survey data (Asprey et al. 2013; Boiko et al. 2014; Edwards et al. 2011).

5.3.4 Impact of OPF on GPs' emotions

As emotion works hand-in-hand with the way an individual thinks about an issue or situation (Maio and Haddock 2010; Solomon et al. 2010), it is important to address

the possible emotional and psychological burdens that OPF may place on healthcare professionals (Strech 2011). It could be argued that negative feedback, whether online or offline, would be disliked in general by GPs, for instance Boiko et al. (2014) observed that GPs find it disheartening to receive consistent negative comments from surveys. Therefore, participants were asked about how receiving positive and negative feedback both online and offline would make them feel.

Most participants in this study felt there was no difference between receiving positive feedback offline and online in relation to their emotions, both would make them feel 'good' (see Figure 5-5) and would reassure them that they are 'doing a good job'.

Figure 5-5: GPs' perceived emotions related to receiving positive feedback (both online and offline). Diagram made using doodle.com.

These feelings are in-line with findings from a study by Davidson et al. (2010) with hospital staff, and what one GP shares in the literature: "These [positive] stories [online] are so inspiring that they make me want to work harder and better for my own patients" (Jain 2010). However, two participants voiced concerns about positive feedback that was left online for all to see. One felt, *"it's a bit navel gazing, oh look at me" (P1)* and the others believed it would be embarrassing:

> *"I might be a little bit embarrassed actually, just because it's like gosh, people are, people are sort of, 'not talking about you' but they are." (P3)*

With regards to negative feedback, as shown in Figure 5-6, most participants felt that receiving negative feedback online was at least one grade worse than receiving it offline: *"I would feel more hurt than offline"* (P8). Furthermore, the emotions described by participants if they were to receive negative OPF ranged from fear to annoyance, unlike offline negative patient feedback, where the most repeated feeling was 'reflective' (which is a positive outcome, while fear was absent). These potential

negative effects on GPs' self-confidence and the resulting impact upon their practice are important and need to be taken into consideration when evaluating the pros and cons of providing OPF websites for patients to give feedback about GPs.

Figure 5-6: Participants' perceived emotions when receiving negative feedback offline, and negative feedback online.
Diagram made using doodle.com

5.3.5 Practice vs physician-based OPF

Participants were asked to choose between practice-based or physician (practitioner)-based OPF websites, which they preferred and felt more comfortable with (see Figure 5-7 for a summary of responses). Fourteen participants felt more comfortable with practice-based feedback (such as the NHS Choices feedback site). This was mainly because it was more anonymous towards GPs, and therefore would make them feel less vulnerable:

> *"... I suppose I am a bit uncomfortable with this sort of naming and shaming type of system." (P4)*

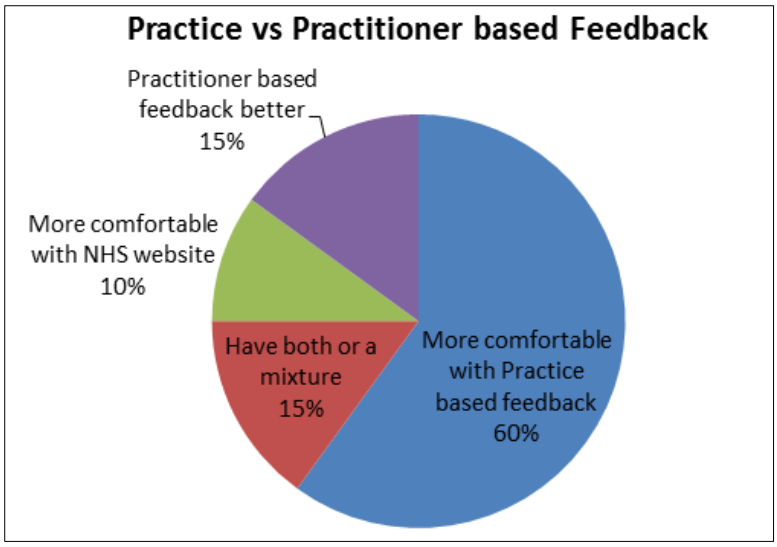


Figure 5-7: Participants' preferences for practice vs practitioner/physician-based OPF website

In contrast, three participants believed that individual feedback (physician-based feedback) would be better, because individual feedback is more useful to improve your own practice, it could be transferred with you when you change jobs, and that negative feedback for one GP could tar a whole practice of GPs:

> *"Sometimes in a practice you might have one GP the patients don't particularly like or there's been a problem with them, and then that whole practice might get tarred with the brush [inaudible] of this one GP … [and] patients may assume that all the GPs in that practice are like that … so I think probably individual GP feedback is better." (P3)*

The concern that a summary rating per practice could mask the different standards provided by the various services and healthcare professionals within a practice has also been raised in the literature (Roberts et al. 2014; The King's Fund 2013). Greaves et al. (2012a) argue that it is more difficult to get an insight into the whole patient experience if the rating or review is just based on the interaction with an individual physician. However, a recent qualitative study in England found that patients believe that in order for ratings to be useful, they would have to be of individual GPs instead of overall ratings of GP practices (The Nuffield Trust 2013). Further research is required to explore whether this finding could be generalized to patients in England and elsewhere.

Three participants appeared to suggest a solution that there should be a mixture of physician-based and practice-based OPF, and one participant suggested that if feedback was about an individual doctor, it should be left under the doctor's name,

whereas if the feedback or review was about the practice, it should be left under the practice's name.

A few participants commented that the NHS Choices feedback site (a practice-based website) was better because it was a government run website (*"an official NHS website"* (P5)) and one participant in particular was cynical of non-governmental websites due to the possibility of profit-making motives:

> *"I'm a bit cynical … I'm suspect [sic] of the motives of starting such a website … where you can profit from advertising." (P20)*

This is in contrast to findings from Davidson et al. (2010) who found that patients and hospital staff in the UK both preferred an independent website rather than a NHS run website because they felt safer on an independent website and trusted it more, and staff believed it was more credible because it was independent. However, the report did not make clear how many patients or healthcare staff were interviewed for the study. Further research is required to look at which type of website (physician vs practice, and independent vs NHS) patients prefer and why.

5.3.6 Perceived future of OPF

Participants were asked whether they think the comments service on NHS Choices should remain as it is, be modified or scrapped (see Figure 5-8 for a summary of responses). Seven GPs acknowledged they did not have enough knowledge about the website to be able to comment. Eight said it should remain as it is, with one commenting on the need for more publicity. Two participants said that it requires more moderation and a further two participants said it should be scrapped because it is not an accurate representation of their practice, and is a waste of resources:

> *"An extra tier of feedback isn't it … I'm not sure it is giving patients or doctors any additional benefit." (P1)*

One participant said that it should be the patients who decide what happens to these OPF websites.

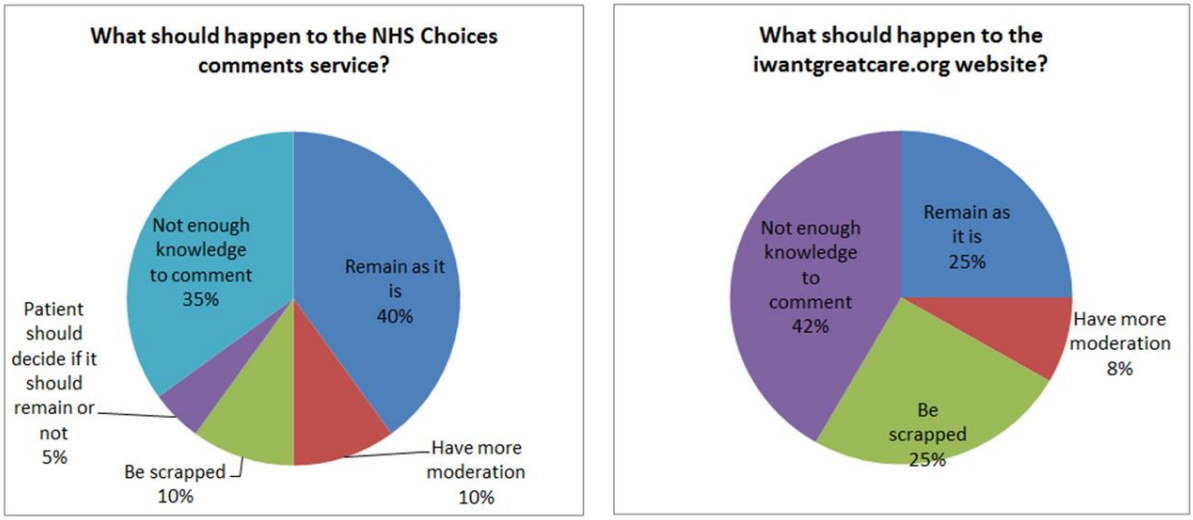


Figure 5-8: Participants' views on what should happen to the two major OPF websites in England

Similarly, thirteen participants were asked about what they feel should happen to the iwantgreatcare.org website (see Figure 5-8 for a summary of responses). Five participants said they do not know enough about the website to be able to comment. Three participants said that it should be scrapped because it names GPs, and therefore it could affect GPs' future employment opportunities:

> *"Don't like the idea of singling out [a GP] ... something like that may affect his opportunities for further employment possibly, if they were to look at that." (P14)*

One participant felt that a third party should not run feedback in the NHS, because the third party may have ulterior financial motives. However, three participants said that the website should remain as it is, and one said that it needs more moderation:

> *"Yeah, it's another way for people to encourage to give [sic] feedback, that's how I see it." [P8]*

Participants were then asked where they thought the future of OPF was. Most participants commented that as the younger generation gets older, OPF usage will increase and become more popular, hinting at a shift in culture:

> *"The younger patients, if they can do it online then it would generate more data ... I think there will be a shift towards online feedback." (P12)*

This is in line with findings that suggest that internet usage for health information is increasing steadily in the UK (Office for National Statistics 2015a), and others such as Gao et al. (2012) are adamant that whether the medical community and policy makers are supportive of OPF or not, OPF will stay and grow. Interestingly, three

participants commented that the future of OPF will be in social media: *"I see it in social network media actually (laughs). I'm quite sure that it will happen" (P16).* However, one participant did not see a future to OPF unless drastic changes were made to it: *"it is currently a confidentiality nightmare" (P17).*

5.3.7 Suggestions made by GPs to improve OPF

Throughout the interviews, nine specific suggestions were made by participants on how OPF could be improved, and these are listed in Table 5-3. Some of these suggestions have been used to produce recommendations for OPF website providers (see Chapter 9).

Table 5-3: Suggestions made by participants to improve OPF websites

#	GPs' suggestion
1	A third party external auditing process that gathers evidence and ensures all feedback is accurate and appropriate before it is posted online. 'Nasty comments' removed by default.
2	GPs should be notified of feedback.
3	GPs should have power of veto.
4	GPs should be able to find out exactly who is leaving the message.
5	The system needs to be developed so that it can verify that the patient is registered at the named practice, by inserting the NHS number, even though the NHS number would not be published or sent on to the GP/practice.
6	Before submitting feedback, patients should be reminded that they can give feedback directly to the practice.
7	Doctors should be on the panel that moderates these comments.
8	The feedback service should be given more publicity so patients are aware that such a service exists.
9	If a patient wants to leave feedback about an individual doctor, they should leave it under the individual doctor's name. If it is a review of a practice, the patient should leave that feedback under the practice's name.

5.4 SUMMARY OF KEY FINDINGS FROM THIS STUDY

A summary of the key findings from this study is presented in Figure 5-9.

Evidence produced in favour of OPF	Evidence produced against OPF
• The majority of participants said they would use OPF to change and improve their practice, as long as the feedback was true • All participants agreed that their younger patients would find OPF websites easier to use than traditional paper based methods of giving feedback • Almost half of the participants agreed that anonymous feedback left online will provide new insights into the perception and needs of their patients • Most participants believe that as the younger generation gets older; OPF usage will increase and become more popular	• A quarter of GPs were unaware that patients can leave feedback for them or the practice on the NHS Choices website • Half of the GPs interviewed had an incorrect assumption about OPF • Most participants believe that OPF is neither credible nor useful to them or to their patients • Majority of the participants believe that OPF is high risk and poses a danger to them and to their patients • Majority of the participants preferred to receive practice-based feedback instead of physician-based individual feedback • Majority of participants said they would not ask their patients to give OPF

Figure 5-9: Evidence produced both in favour of and against OPF websites based on findings from this study

5.5 CONCLUSIONS FROM THE STUDY

Despite the NHS requesting patients in England to leave reviews and comments on a government run website (NHS Choices 2015), a quarter of GPs interviewed in this study were unaware that patients can leave feedback for them or their practice on an official NHS website. Furthermore, half of the participants mentioned an incorrect assumption about the NHS Choices feedback site. This suggests that GPs currently have limited knowledge and awareness of OPF, although they do believe that as the younger generation gets older, OPF usage will increase and become more popular.

The majority of GPs interviewed in this study had concerns and reservations about OPF because they felt that OPF was not an accurate representation of their performance due to user bias and data bias. They were also worried about the impact this could have on them, on their practice, as well as their patients, who may use these 'questionable online ratings' to make an 'invalid choice' of which healthcare provider to use. GPs in this study also felt that due to the transparent nature of the feedback online, and due to what they perceive as a lack of regulation, there is a high risk of false allegations being left about them, which could have an impact on them personally, on their family, on their professional practice (more defensive medicine), and on their relationship with their patients. Other GPs questioned the usefulness of the OPF if the feedback is left anonymously, but acknowledged the benefits to patients of leaving feedback anonymously. A few participants also argued that there was no current evidence to prove OPF's usefulness to GPs or patients.

Many of the participants also believed that the OPF website providers were not doing enough to regulate these comments and were worried about allegations being made against them, which they felt they would be unable to defend online, due to the public nature of such websites. Only four participants said they would ask their patients to leave feedback about them online. Despite this, half of the participants in this study believe that OPF has the potential to provide new insights on their patients, and the majority of participants were happy to use OPF to improve their own performance and care. When asked specifically about the NHS Choices feedback site and iwantgreatcare.org, only 10% to 25% called for it to be completely scrapped. Moreover, all participants agreed that OPF would be an easier way for their younger patients to give feedback, and most participants agreed that OPF will become more popular as the younger generation gets older. This suggests that GPs could be convinced of the value of OPF, if their concerns about OPF websites were addressed.

In summary, although the majority of participants were happy to use OPF to improve their own performance, and some participants acknowledged the benefits of OPF especially to younger patients, most participants in this study had concerns about OPF. They questioned, amongst other things: the validity of OPF because of data and user bias and lack of representativeness; the usability of OPF due to it being anonymous; the transparency of OPF due to the risk of allegations and breaching confidentiality; and the resulting impact of all those factors upon them, on their professional practice and on their relationship with their patients.

The findings suggest that most of the concerns raised by GPs may in fact be valid and need to be addressed by OPF feedback providers and other OPF stakeholders. If the NHS and other OPF website providers for example want GPs to take these reviews seriously and for the ratings per practice to be 'valid' and representative (so that patients can make an accurate 'choice'), they need to do more to get patients to leave reviews. Promoting OPF amongst GPs and reassuring them of the safety and usefulness of such websites, may also mean GPs are more likely to use OPF for their own professional development, and encourage their patients to leave feedback on OPF websites. Other recommendations for OPF website providers based on findings from this study can be found in Chapter 9.

5.6 LIMITATIONS OF THE STUDY

The aim of this descriptive study was to explore GPs' views about OPF as a mode of feedback in general practice, and the qualitative findings from this study were not intended to be representative of all GPs in England. It must be acknowledged that the sample size for this study was small (n=20), and because 60% of participants were between the age of 30-34, there may have been a sample bias towards more technology savvy GPs. Earnest attempts were made to recruit participants randomly to get GPs of different ages and backgrounds, and over a quarter of our participants were recruited using probability sampling. However, little difference was found in internet usage of all the participants of different age groups in the sample.

It must also be acknowledged that GPs were only recruited from three different locations in England (Northwest of England, Cambridgeshire and London), with almost half from the Northwest of England, which may have introduced a geographical bias to the data. Furthermore, a limitation of the analysis of the data in this study is that although the coding frame and the thematic maps were checked by the researcher's supervisors for accuracy, the raw interview transcripts were not second coded by another researcher to assess coding consistency and reliability.

Despite the findings not being representative of all GPs in England, the findings highlight key advantages and disadvantages of OPF from the GPs' perspective and place them into the context of existing literature and viewpoints. This helped form recommendations for feedback providers and can help inform further research in this area (see Chapter 9).

CHAPTER 6 - STUDY B (PHASE 2): EXPLORING PATIENTS' VIEWS ON GIVING FEEDBACK ABOUT GPS USING OPF

6.1 INTRODUCTION

As discussed in Chapter 3, studies conducted outside of England have explored the types of patients who use OPF websites (Bidmon et al. 2014; Emmert and Meier 2013; Emmert et al. 2013a; Hanauer et al. 2014b; Terlutter et al. 2014). In England, two studies explore patients' awareness and consideration of their future use of doctor rating websites, as well as some of the demographic predictors for people willing to leave feedback on doctor rating websites (Galizzi et al. 2012; The Tavistock Institute 2011). However, none of these studies have explored patients' own views on OPF websites, such as whether they perceive any benefits or risks in relation to leaving feedback online, or what may motivate or dissuade them to leave feedback online (Powell et al. 2015). There is also little understanding of how these attitudes and preferences differ from attitudes and preferences towards other feedback methods.

6.2 AIM

The aim of this study was to explore patients' views about giving online feedback and ratings on GPs in England, within the context of other feedback methods available in general practice, in particular paper-based feedback cards. The intention is to use the findings from this study (presented in this chapter[6]) to create a questionnaire that could be used across England to explore nationwide public views and understanding regarding giving feedback online about GPs.

6.3 METHODS

6.3.1 Data collection

This study was exploratory and descriptive in design because there was very little known about patients' views towards OPF websites. Qualitative semi-structured interviews were carried out because this gave the depth required, and allowed probing of participants (Tracy 2012). A deductive conceptual framework was created (see Figure 6-1) based on findings from Study A and existing literature. This, as well as

[6] The material presented in this chapter has been published in Patel et al. (2016).

guidance suggested by Bryman (2008) and Matthews and Ross (2010), were used to design the topic guide (see Appendix D for a copy of the topic guide). The topic guide was piloted on two members of the public (one male, age 30; and one female, age 46) prior to use in the interviews, and following which the structure of the sentences in three questions was modified, because the sentences were too lengthy.

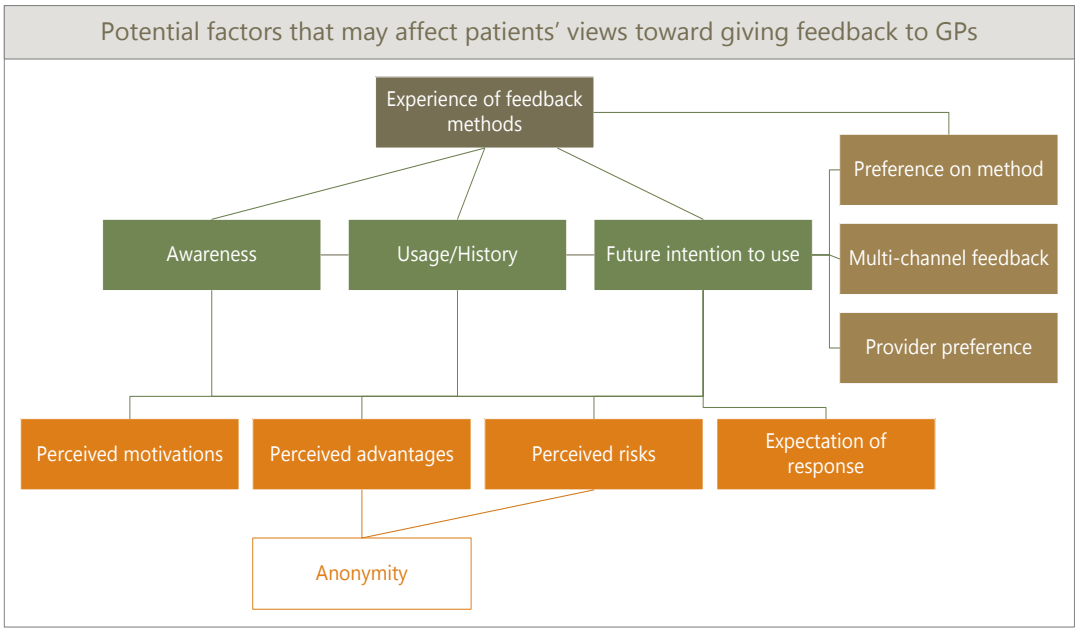


Figure 6-1: A deductive conceptual framework used to design the topic guide

6.3.2 Interview materials

Two materials were used in the interviews to provide information to participants. The first was the NHS Friends and Family Test card. These cards or forms are available in most GP Practices, and GP Practices are contractually obliged to provide these as a method for patients to leave feedback (NHS England 2014b). The design of the cards or forms can vary in each surgery, and the one used as an aide for this interview was the same one found in six GP surgeries local to the researcher (in East London). This card was used in all interviews (see Appendix D for a copy), and participants were asked questions about their experience and attitudes towards them.

The second material (see Appendix D) contained a screenshot of a GP Practice page on the NHS Choices website, which included reviews and ratings left for a practice. This material was used in all interviews to introduce participants to the concept of OPF websites, and to ensure that they had correctly understood the meaning of OPF websites.

6.3.3 Card sorting

Card sorting exercises are used in qualitative research to understand and encourage discussion about the reasons for particular choices and preferences (Ritchie et al. 2013). Therefore, two card sorting exercises were used to help participants explain which methods they would most prefer to use to leave feedback about GPs. The methods selected were based on feedback methods mentioned by Brown et al. (2009), Silva (2013) and Coulter (2006) in patient feedback literature, and are listed in the topic guide (see Appendix D). Figure 6-2 shows a participant sorting out the cards during the interview.

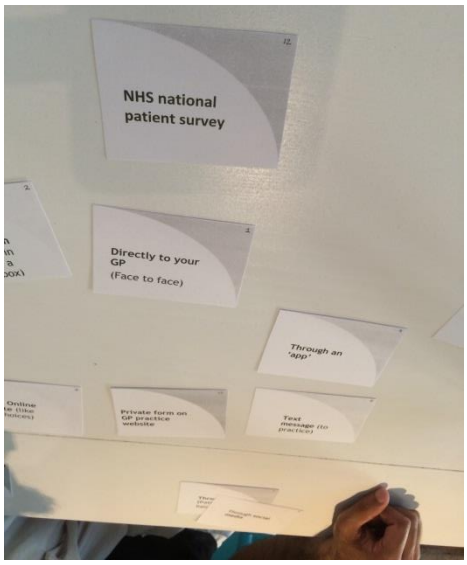


Figure 6-2: A picture of a participant sorting out the cards during the interview

6.3.4 Sampling and recruitment

Purposive sampling was used to recruit participants so that the sample would represent three patients from each age group between the ages of 20 and 80 years. Participants were screened before recruitment to ensure they had at least one consultation with a GP in the past year. A total of eighteen participants (10 female; 8 male) were recruited (see Table 6-1) from four locations in England: East London (n=11), North London (n=3), South London (n=2) and Coventry (n=2). From the eighteen participants, five were retired, three worked as volunteers, one was unemployed and the remaining nine participants were in full time employment.

A recruitment poster (see Appendix D for a copy) was placed in community centres and cafes in two areas of East London. The researchers' acquaintances based in North

London and South London were contacted using email and telephone in an attempt to recruit them to participate in the study. In Coventry, an email was sent to all staff at the WMG department at the University of Warwick inviting them to participate in the study.

Fifteen participants were interviewed initially, after which the data was analysed, because the data appeared to have reached close to thematic saturation. Then, three further interviews were conducted and analysed, and the themes that emerged validated and supported the existing themes found. The data was now believed to have reached thematic saturation (O'Reilly and Parker 2012), and therefore no further interviews were conducted.

Table 6-1: Participants' age and gender

Age group	Male	Female	Total no. of participants
20-30	2	1	3
30-40	1	2	3
40-50	1	2	3
50-60	1	2	3
60-70	2	1	3
70-80	1	2	3
Total participants	**8**	**10**	**18**

6.3.5 Study interviews

Participants were sent an invitation letter and information sheet either through email or in-person beforehand (see Appendix D), and were interviewed using the topic guide in a private meeting room or at the participant's home. Informed consent was obtained from all participants prior to the interviews. The length of each interview had a mean average of thirty minutes, and all interviews were recorded using a digital recorder to aid analysis.

At the start of the interview (see Appendix D for the topic guide), patients were clearly informed that when asked about 'feedback', it included both negative and positive: comments, reviews, ratings and complaints that the patient may give or has given about their GP, and that the focus was solely on feedback about their experience of receiving care from GPs, not the GP practice nor other staff in the practice.

6.3.6 Data preparation and analysis

The primary goal of the analysis was to identify key themes, and therefore an inductive (data-driven) thematic analysis was appropriate (Guest et al. 2012). Although thematic analysis shares features with grounded theory and phenomenology, it is not restricted to building theory or subjective human experience (Guest et al. 2012). Hence, it can be used within different theoretical frameworks (Braun and Clarke 2006), and subsequently has greater flexibility about the analytical tools it can employ (Guest et al. 2012). Guest et al. (2011) introduced the Applied Thematic Analysis (ATA) approach which is based on the commonly used inductive thematic analysis but has a pragmatic focus. It allows the use of whichever tools are appropriate for the analytical process, such as structural coding, quantification, word searches, and deviant case analyses. ATA was used to analyse the interviews in this study, and the specific procedure used was as follows:

1. Familiarisation: As interviews were conducted, they were transcribed in Word and initial ideas were noted into an analytic memo in Word. Once 15 of the interviews were complete, they were exported into NVivo.
2. Structural Coding: A structural coding framework consisting of 25 sections was created in NVivo based on topic areas and questions in the topic guide. The framework was applied to all 15 interviews, across the data set. This was possible because the topic guide was well-structured, and the structure had been followed during the interview.
3. Coding content: Some sections were coded individually whilst other sections, where appropriate, were coded together. Data was collated relevant to each code and a codebook was then created in Word for each section, naming each code, description and an example from the data. As the codebook developed and the entire data set was coded, codes were refined and deleted both from NVivo and the codebook. Data was not coded for specific research questions but some research questions did evolve through the coding process.
4. Quantitative data reduction: Some quantitative reduction techniques were used where appropriate to increase the efficiency of the analysis and the reliability of the findings. For example, frequencies were counted to understand which methods of giving feedback were most preferred by participants.

5. Generating themes: Using the codebook, some individual codes formed potential themes whilst other codes were collated together to form potential themes, sub-themes or were discarded.
6. Reviewing themes: Themes were checked against the code book and negative and deviant cases were searched for. The relationships between the codes, between themes, and between the different levels of themes were examined.
7. Introducing new data: Three new interview transcripts were added on at this stage, and went through stages 1-6 mentioned above. No new themes emerged.
8. Creating and defining major themes: Analysis continued to refine the specifics of each theme, and major themes were formed and defined using the codebook.
9. Producing explanations: In this final stage of analysis, explanations were formed and where appropriate, the major themes were related back to the research questions and literature.

6.4 RESULTS & FINDINGS

6.4.1 Overview

Participants were asked about their views on giving feedback about their experience of receiving care from GPs, with a focus in particular on OPF websites and paper-based feedback cards. Participants discussed their awareness and past usage of the online and offline modes of feedback to leave feedback about a GP, as well as their attitudes, motivations and consideration for future use of both OPF websites and paper-based feedback cards. The interviews focused mainly on the NHS Choices website as the OPF mode, and the NHS Friends and Family (test) feedback card as the offline mode to leave feedback (see Figure 6-3), both of which are available in general practice in England, and are generally unsolicited forms of feedback.

Figure 6-3: Example of a box that NHS Friends and Family Test cards are posted into at a GP practice

This chapter presents the major themes that emerged from the data. The first four themes (1-4) were not specific to a method or mode of feedback; rather, they were found in relation to both paper-based feedback and OPF websites. The final three themes (5-7) were unique to OPF websites, and they allude to the additional considerations that patients need to make when considering using OPF websites to leave feedback about a GP.

6.4.2 Theme 1: Limited awareness of methods to give feedback about GPs, especially online

In this study, five participants had given feedback about a GP in the past using non-online methods, and the remaining thirteen had not. Interestingly, however, almost half of the participants (n=8) did not know that they could leave feedback about a GP using any method:

> *"I haven't seen this [NHS Friends and Family Test card] before, probably haven't looked" (P18)*

Similarly, the majority of participants (n=16) were not aware of the existence of OPF websites, and only one female participant aged 47 had experience of giving feedback on an OPF website about a GP. Nevertheless, more than half the participants (n=12) said they would happily leave feedback about a GP if they were asked to by the GP or the practice, and thirteen participants said they may consider giving feedback online or on paper in the future.

6.4.3 Theme 2: Preference for mode of feedback depends on nature of feedback

The majority of participants preferred to give positive feedback directly face-to-face to the GP, and almost half also preferred to give negative feedback directly face-to-face to the GP:

"If I was unhappy with my GP I would make an appointment and tell her that I was unhappy. I wouldn't mess about." (P16)

The other methods by which participants most preferred to give feedback were through an app, filling in the NHS Friends and Family Test card, giving the feedback to the practice manager, and leaving the feedback on a private form on the GP practice website (see Figure 6-4).

Participants in this study were not keen on using social media (such as Facebook or Twitter) to leave feedback for a GP, emailing or texting the feedback, or using the national patient survey. Among the digital methods the least popular with participants was social media, followed by emailing the GP directly and text messaging. Three participants (aged between 35 and 55) mentioned the OPF website in their top three preferred ways to leave feedback about a GP. However, almost all participants added a caveat and said that their preference of method for giving feedback about GPs would actually differ depending on the nature of the feedback, that is, whether the feedback was positive or negative:

"It depends [on] what feedback you are giving" (P1).

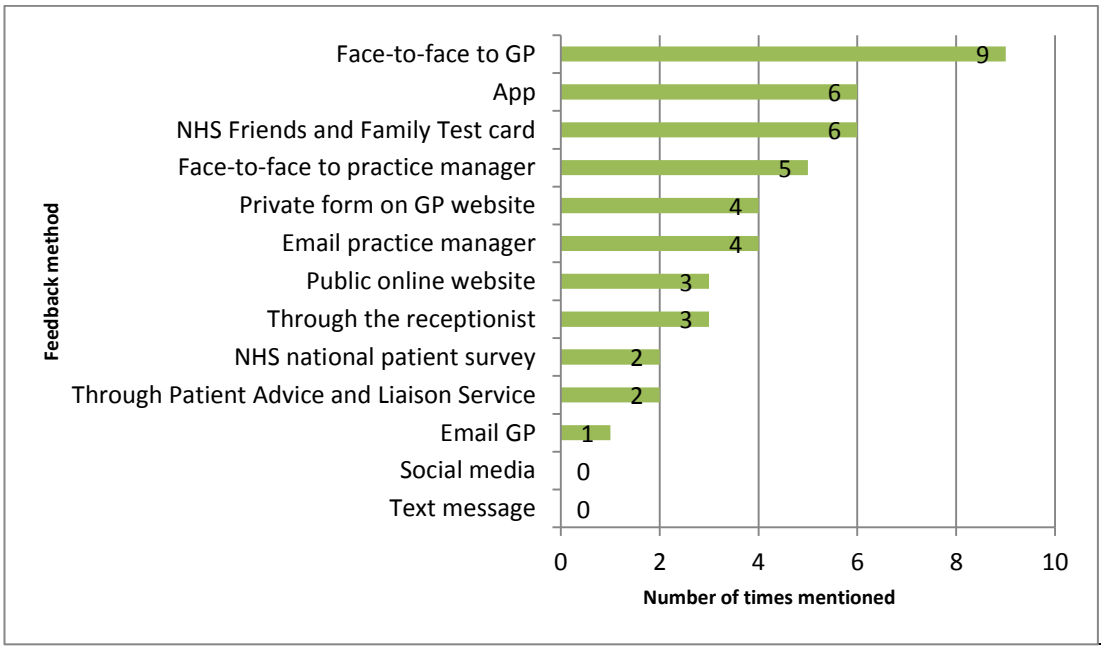


Figure 6-4: A chart showing the number of times the feedback method was selected (through card sorting exercise) in participants' three most preferred ways to leave feedback about a GP

6.4.4 Theme 3: Extreme experience is the primary driver to leave feedback, both on paper and online

Almost all of the participants (n=17) described their past experience with a GP as satisfactory or good and therefore they felt that there was no need for them to leave feedback about a GP:

> *"I suppose it feels a bit silly to make the effort to go to give feedback to say 'yeah everything was fine'." (P1)*

However, all participants (n=18) agreed that if they experienced an extreme experience in the future, they would leave feedback for a GP:

> *"If I felt that the level of service [was] exceptionally good or exceptionally poor, I'd be inclined to leave feedback." (P15)*

Furthermore, the majority of participants said they were more likely to leave feedback (online or using any other method) when they had experienced an extreme negative experience, rather than an extreme positive experience.

6.4.5 Theme 4: Patients need to be convinced that feedback is needed and will be used for improvement, for both paper and online feedback

Many participants questioned whether the feedback they leave for a GP would lead to any kind of improvement. Half of the participants (n=9) believed that giving feedback about a GP would not make a difference to the GP's behaviour or practice. Five participants were unsure whether the GP would even see the patient feedback or respond to it. Furthermore, more than half of participants (n=13) believed that GPs do not want patient feedback, otherwise GPs or the practice would ask them to leave feedback for them:

> *"If I was given a card every time I went and they said 'can you tick it' then I would tick it and pop it in the box on the way out, but it seems sort of an odd thing to do if I don't know they [GPs] particularly want it." (P1)*

Four participants said that a GP does not need feedback, and a quarter of participants (n=6) said that GPs could utilise their time better by treating patients instead of using their time to read patient feedback. However, more than half of participants (n=12) said they would happily leave feedback about a GP if they were asked to do so by the GP or the practice:

"If the paper [to give feedback] was given to me, I would definitely leave feedback." (P7)

Furthermore, more than half of participants (n=13) explained that if they were to leave feedback about a GP in the future, their reason for doing so would be to highlight good and bad practice, and identify opportunities for improvement:

"I think it's good to highlight good practice, where things go well … but equally with regards to whether [sic] things don't go as well." (P4)

6.4.6 Theme 5: Transparency of OPF websites

Twelve participants believed that patient feedback being online and in the public domain is advantageous for patients. Seven participants explained this was because the public and other organisations could benefit from such feedback because they could evaluate how well GPs and GP practices were performing from patient experiences:

"Because it is public isn't it, and shows the whole world [sic] can see how well the practice is doing." (P6)

Other participants (n=4) explained that because the feedback is in the public domain, GPs and GP practices would take patient feedback that is online much more seriously than feedback left using other methods, because they would feel more accountable:

"With online, because it is in the open, once it is there, it is pretty much like a branding for them, so it's almost like they have to take it more seriously." (P10)

In addition, two participants believed that patient feedback being online was advantageous to the GP practice too, because feedback would be easier to collate and there would be less room for error when transferring that feedback to GPs. However, three participants believed that these types of OPF websites could be a breeding ground for false complaints, negativity and abuse:

"If you put things that are negative online, it just creates a breeding ground for more … and then becomes a slating of the surgery." (P2)

One participant said that because of this, the GP practice may actually view the feedback left on these websites with scepticism, which according to her, defeats the purpose of leaving feedback to bring about change or improvement. Similarly, five

participants (most of them older than 60 years) argued that these types of feedback websites are not useful to them or to the public:

> *"What's the value in people scrolling down and reading I've had a particularly good or bad experience?" (P9)*

6.4.7 Theme 6: Concerns about privacy, security and anonymity of OPF websites

More than half of participants (n=10) from all age groups had privacy concerns about leaving feedback online, and were worried that their identity could be traced, even when leaving feedback anonymously. In contrast, only two participants felt that their identity could be revealed if they left feedback for a GP using the NHS Friends and Family Test card. One participant was worried that disclosing her identity when leaving negative feedback online or using any other method could risk damaging her relationship with her GP. However, when participants were asked specifically whether they believed leaving negative feedback about a GP would have an impact on their relationship with a GP, most participants believed that GPs were professional, and therefore leaving negative feedback for a GP would not have an impact on their relationship.

Leaving their real name online – Six participants said they were happy to leave their real name online when they left feedback about a GP on an OPF website, because they believed their feedback would be more effective with their name on it, so that GPs could then use the feedback for improvement:

> *"I always think it is important to [leave one's name], because if you don't, then that person can't get back to you to say how can we improve? Because I always believe it should always be solution focused." (P5)*

Furthermore, one participant mentioned that he would be happy to leave his real name on negative feedback online because he could always see another GP in the practice. However, seven participants from all age groups were not happy to leave their real name online due to privacy concerns. They had a need to remain anonymous, and were worried they could be identified by a GP.

Leaving information about their diagnoses online – More than half of the participants said that if their diagnosis was a commonly occurring diagnosis, they

would not mind leaving it online. However, if it was quite specific or an embarrassing ailment, they would hesitate to leave it:

> *"I've had both my hips replaced, I don't mind people knowing that … if it was a very personal issue than probably not. Same with online." (P4)*

Naming a GP when leaving feedback online – The majority of participants were happy to name a GP when they left positive feedback about them online. However, when leaving negative feedback online, participants disagreed as to whether a GP should be named. Four participants said that feedback would be more useful if a GP is named. One of the reasons given was that if the patient wants improvement, the GP's identity needs to be explicit in the feedback, especially if the GP is part of a larger practice:

> *"There are 18-20 [GPs] working on the same day [in my GP practice], it's hard to know which doctor you are talking about." (P3)*

However, seven participants felt that it was unfair to name GPs online, because the feedback left online could damage the GP's reputation or personal confidentiality, and it could just be that the GP was having a bad day:

> *"I think they deserve privacy. I live in the public world and I know how that feels, and if I fail I don't necessarily need it everywhere, and same with them." (P6)*

6.4.8 Theme 7: Accessibility of OPF websites

Almost half of participants (n=7), all under the age of fifty, believed that an online feedback website is more accessible because it is available all the time and can be used from anywhere, and therefore it is also easier to use:

> *"Yeah, 'cos you can do it [give feedback] any time. You know you don't have to do it there and then. Or you don't have to go home and come back to collect something paper-based, you can do it at home, 2am in the morning." (P2)*

Furthermore, one participant, who was under the age of thirty, suggested that giving feedback online would make it easier for her to be critical of her GP:

> *"I think I would feel more comfortable typing it [i.e. critical feedback] (laughs), it's just, I don't know, I think it's just psychological, I just feel like if I put it down myself [on*

paper], I wrote it, then it'd be, yeah, I wouldn't feel as comfortable being as expressive that [sic] I'd like to be. Is that weird?" (P3)

However, more than half of the participants (n=11) expressed that a website is less accessible. Four participants (who were all over the age of 60) said this was because they do not have a computer or they do not know how to navigate a website, whilst others who were familiar with the internet and used the internet felt they did not want to go online for non-work purposes.

6.5 DISCUSSION

6.5.1 Principal findings

In this study, patients as a group are divided about their attitudes towards using OPF websites in the future for leaving feedback about a GP. Some patients do not want to give feedback or do not feel the need to do so in future (regardless of the method of feedback offered to them), whereas others who may be willing to leave feedback about a GP, are for or against leaving feedback on an OPF website.

The results suggest that some patients may be motivated in the future to leave feedback on an OPF website rather than through paper-based feedback either because: i) they can give feedback anytime from anywhere, ii) it allows them to share their experience with the public so others can see what went right or wrong, or iii) they believe that the GP will take online feedback more seriously. On the other hand, others suggested that they would not use an OPF website to leave feedback because either: i) they cannot use a PC or website (mentioned only by participants above the age of 60), ii) they have privacy concerns about leaving feedback online, or iii) they believe that feedback left online will not be taken seriously by the GP or practice, because other patients may be abusing the website or using it as a negative breeding ground. These findings can be used by the NHS and OPF website providers to effectively target marketing material and address these patient concerns about OPF websites that have emerged from this study.

Although participants under the age of fifty appeared to perceive giving feedback online easier than giving it on paper, this does not mean that they were convinced of the value of giving feedback about a GP on a public OPF website. Privacy and security were important to all of the participants in this study regardless of age, and this

suggests that if patients feel a website is not secure enough or will not preserve their anonymity, they will be reluctant to use such a website to leave feedback about GPs. The NHS and other OPF website providers need to reassure patients that their websites are secure, and will maintain patient privacy.

6.5.2 Comparison with prior work

Since 1978, Patient and Public Involvement (PPI) has been part of NHS policy, and there has been increasing emphasis on collecting patient experience narratives and feedback both in the NHS and outside of it (Ahmed et al. 2014). It was surprising, therefore, that half of the participants in this study were not aware they could leave feedback for or about a GP. In addition, the majority of participants were also not aware of the existence of OPF websites. However, the latter finding is in line with a study by Galizzi et al. (2012) which found that only 15% of a sample of Londoners were aware of doctor rating websites. This is in contrast to Germany and the USA, where recent studies found that approximately a quarter of respondents had used a doctor rating website (Emmert et al. 2013a; Terlutter et al. 2014). This may be partly because of the higher usage of private healthcare in the USA and Germany.

One of the criticisms of the NHS Choices website in England raised by GPs in Study A is that its user-driven content is biased and it contains very few numbers of reviews and ratings, which are not representative of a GP or GP practice's performance. This was supported by a study in England, which found that only 0.005% of all GP consultations had been reviewed online (Greaves et al. 2012b), and studies from the USA (Ellimoottil et al. 2013; Gao et al. 2012; Lagu et al. 2010; Mostaghimi et al. 2010), Germany (Emmert and Meier 2013; Reimann and Strech 2010) and Australia (Atkinson 2014) all indicated that less than 30% of doctors had been rated online. GPs in Study A also suggested that their patients are not aware about the existence of OPF websites. The findings from this study appear to support this. However, they also suggest that the lack of awareness and usage among patients is not limited to OPF websites; rather, patients appear to have limited awareness of other feedback methods that are present in GP practices. More positively, participants also suggested that this could be reversed if the GP or practice actively asked them to leave feedback about a GP (rather than by just providing tokenistic methods, such as leaving forms at the reception desk), and this may convince them that their feedback, even if the feedback is mediocre, is of some value to the GP or practice for improvement.

Despite the phenomenal increase in internet usage and ownership of computers in UK households, there is still a digital divide present in society, where 11% of adults in the UK in 2015 have never used the internet (Office for National Statistics 2015b), and 37% of 65-74s and 65% of over-75s do not have access to the internet at home (Ofcom 2015). This was also reflected in this study, where almost all of the participants over the age of 60 said they did not have access to a computer or the knowledge to use such websites. This suggests that some groups in society, mainly the elderly, may be excluded from OPF websites, and Trigg (2011) proposed that this may be a type of social exclusion for those who most need healthcare and access to OPF websites. Interestingly though, even among those who did have access to the internet in this study and who were familiar with the internet, a few just did not want to use the internet for purposes outside of work.

Patients in this study felt that their primary motivation to leave feedback for a GP (irrespective of whether it is online or on paper) was to help improve GPs' professional practice, and this may explain why many in this study preferred to leave feedback directly with the GP or practice, because they believed the GP could then make the necessary changes. This type of motivation is described as 'helping the organisation' by researchers in the field of consumer behaviour, who explore what motivates people to communicate positive and negative sentiments through word-of-mouth about consumer products (Sundaram et al. 1998; Trigg 2012). However, the difference is that this type of motivation was attributed to positive feedback only, whereas in this study, patients attributed it to negative feedback too. This also appears to dismiss the concerns raised in the literature (Greaves et al. 2012b; Kadry et al. 2011; Lagu and Lindenauer 2010; Segal 2009) and by GPs in Study A, that some patients have malicious intentions when they leave feedback online.

Two additional perceived patient motivations for leaving feedback online were found in this study, and these were exclusive to leaving feedback online for GPs. The first of these perceived motivations would fall under the term 'altruism' described in the field of e-consumer behaviour (Parikh et al. 2014); this was the ability to benefit other patients and organisations by sharing feedback in the public domain, so that: a) it ensures others do not share the same negative experience, and b) other patients can use the reviews to decide which GP to see or which GP practice to join. The latter has been part of the 'patient choice' agenda in the NHS (Adams 2013; NHS Choices 2015),

and the NHS argues that this type of 'choice' will drive improvement and empower patients (Department of Health 2003). More than half of the participants in this study spoke positively of this advantage; however, there has been considerable criticism of the choice agenda in the literature (Dixon et al. 2010; Fotaki 2014).

The second perceived patient motivation to give OPF mentioned in this study was its collective power to force improvement. This exercising of power over an organisation has also been described by Yoo and Gretzel (2008) as a motivator for people leaving online travel reviews. Similarly, Ben Bradshaw, a former British Minister for Health, argued that OPF will force doctors to improve their performance and bedside manner out of fear that patients may post online about them (Carvel 2008; Symons 2008). However, the majority of GPs in Study A disagreed that this would bring about a positive change; rather, they believed it would just force GPs to practice more defensively. Davidson et al. (2010) also found that just because stories about the quality of services appeared in the public domain and affected an organisation's reputation, this did not mean that they would automatically become drivers for improvement in the NHS. Furthermore, one participant in this study highlighted that leaving feedback online, she believes, will not be taken more seriously by the GP as the feedback may be looked at with scepticism, because OPF websites can be seen as negative breeding grounds by GPs. This appears to be supported by some GPs in Study A, who saw little value in OPF and had concerns about it.

Patients' views about leaving their name on future feedback that they leave online were found to be mixed. On the one hand, some patients had concerns about privacy, whereas others suggested the feedback would be more useful to GPs if they as patients left their name on it; and seven GPs in Study A also believed the same. Similarly, views were mixed about whether GPs should be named on feedback provided online, and Study A found that GPs preferred to receive practice-based feedback, where they as GPs would not be named by the patient on the feedback left online. However, four participants in this study believed that feedback would be more useful if the GP is named, because there is no other way to identify the GP, especially if the GP is part of a larger practice. In Study A, some GPs similarly questioned the usefulness of a piece of feedback if it was anonymous to GP and the patient, and remarked that it was difficult to work out who the comment was for and about, and therefore could not be used for improvement.

Findings from this study suggest that there is no single most preferred method for patients to give feedback about a GP, and Entwistle et al. (2003) also found the same in their study with Scottish patients. However, in this study, giving feedback directly to the GP and the practice was the most preferred way for the majority of participants to leave feedback. This is significant, because it appears that some patients do not feel the need to formalise the feedback they give about a GP. The results also suggest that if patients feel heard within the practice, they may be less likely to seek out other external ways to leave feedback.

In addition, the results from this study indicate that patients will change their method of giving feedback based on the type of feedback they want to leave (negative or positive), and the type of experience they have. This is significant because it suggests that patient feedback left online for a GP – that other patients can then use to make a 'choice' of provider – may very well be biased, because patients seem to pick and choose which type of feedback they place online and which, for example, they directly tell their GP after a consultation.

All of the participants in this study said that they would consider leaving feedback for a GP (online or using another method) in the future when they had experienced an extreme experience, mainly an extreme negative experience. This appears to support the argument made by GPs in Study A as well as physician representatives (Boffey 2011; McCartney 2009) that the majority of OPF is extreme negative opinion. This is usually counteracted in literature with the statement that studies in the UK and elsewhere have found that the majority of feedback left on OPF websites is positive (Verhoef et al. 2014). The findings from this study appear to contradict that and further suggest that regardless of whether patient feedback is given online or not, patients are much more likely to leave feedback when they have an extreme negative experience.

Most participants in this study felt quite comfortable giving negative feedback directly to the GP, and they did not believe leaving negative feedback for a GP would have an impact on their relationship with a GP. This contradicts Dorr Goold and Lipkin's (1999) stance that the doctor-patient relationship is 'sacred', and therefore patients would not risk jeopardising that relationship. However, it appears to support the argument by Kaba and Sooriakumaran (2007) that the one-sided power in a doctor-patient relationship is swiftly shifting in the UK, and the push for patient-

centred care means that both parties are now more likely to be involved in decision-making processes.

6.6 CONCLUSIONS OF THIS STUDY

The findings of this study appear to suggest that the current low usage of OPF websites in England may be partially because many patients do not know that they can leave feedback at all about GPs, online or offline, and within the group that does know about leaving feedback for GPs, some do not want to leave feedback, regardless of which method of feedback is offered to them. This is in part because they are not convinced that GPs want or need patient feedback. However, the findings also suggest that those patients who do want to leave feedback about a GP would choose the method based on the following: the type of feedback they want to give, whether that particular method of giving feedback was convenient for them, whether they believed the feedback method was secure and appropriate to use, and whether they believed that the feedback would reach the GP using that method and would be used for improvement. These generic factors (found in this study) associated with preference of feedback method may be used by the NHS and other healthcare providers to evaluate whether proposed new methods to collect patient feedback are appropriate and will be effective.

The findings also suggest that OPF websites as they currently are will not replace other mechanisms for patients to give feedback to a GP, but they may motivate a small number of patients who have more altruistic motives or wish to place collective pressure on a GP to leave feedback online. If the NHS or GPs want more patients to leave feedback online, the findings suggest they first make patients aware that they can leave anonymous feedback securely online for a GP. They could then convince them actively that their feedback is needed and wanted by GPs for improvement, and that the reviews they leave online will be of benefit to other patients to decide which GP to see or GP practice to join. The findings also suggest that some patients may prefer to give feedback using an online method because it is easier and more accessible, but at the same time they may want their feedback to remain private for the GP or GP practice to view only. Future research will explore this and examine whether the other findings from this study can be found at a population level in England.

6.7 LIMITATIONS OF STUDY

Findings from this study provide valuable insight into patients' views and motivations regarding OPF in the context of general practice. However, the findings need to be used with some caution. Even though the data appeared to reach thematic saturation, the sample size for this study was small (n=18) and a convenient sample was used. Furthermore, participants were recruited from London and Coventry only, which may have introduced geographical bias to the data. Therefore, it is difficult to conclude to what extent findings can be found in the general population of patients.

A further limitation of the analysis of the data in this study is that although the coding frame and the codebook was checked by the researcher's supervisor for accuracy and consistency, the raw interview transcripts were not double coded by another research, and this also meant that inter-rater reliability could not be assessed.

Nevertheless, the findings are useful for scoping further research, and the next study (in Chapter 8) will examine the extent to which findings from this study can be found at a population level in England.

CHAPTER 7 - PHASE 3: DEVELOPING AND VALIDATING A QUESTIONNAIRE TO MEASURE PUBLIC AWARENESS, USAGE AND ATTITUDES TOWARDS OPF

7.1 INTRODUCTION

The previous chapter illustrated how qualitative methods were used to explore patients' views on giving feedback about their GP, with a particular focus on using OPF websites. Prior to this study, in England, only one published survey by Galizzi et al. (2012) could be found that was relevant to patients' views towards OPF. Although this survey explored public awareness and intention to use doctor rating websites, it did not explore for example what motivates patients to leave feedback about their GP. Or for example, why patients may want to or not want to leave feedback about their GP, both online and offline, using the different methods that are available or could be available in general practice. Therefore, a new population questionnaire had to be designed to meet the objectives of this research.

A population questionnaire measures the views of the public, and aims to be representative of public views. It is also vital to develop a questionnaire that is valid, reproducible and accurate (Groves et al. 2009). This can be done by evaluating survey questions and ensuring that there is no measurement or observation error, and that the questions are accurately measuring what they intend to measure (Groves et al. 2009; Leeuw et al. 2008). Therefore, this chapter reports on how the questionnaire was developed, evaluated and validated before implementation in Study C (Chapter 8).

7.2 AIM

The aim was to develop and validate a population questionnaire to measure public awareness, usage and attitudes towards the use of OPF websites for giving feedback about their experience of receiving care from GPs in England (within the context of other feedback mechanisms available in general practice).

7.3 QUESTIONNAIRE TOPICS

During the period of September-November 2015, a draft questionnaire was designed using findings from Study B, existing literature on OPF, a survey used by Galizzi et al. (2012), and two existing unpublished questionnaires about OPF obtained from Patient Opinion (James Munro, personal communication, Sep 1, 2015 (Patient Opinion 2015a)) and Deborah Davidson (personal communication, Dec 13, 2011 (Patient Opinion 2011)). Based on key findings from Study B, the decision was made to focus on i) understanding public views towards OPF websites, ii) evaluating whether OPF websites are needed or wanted by patients in the UK, and iii) determining whether alternative methods of giving feedback about GPs are sufficient or more preferred. Therefore, in order to achieve the study aim, the questionnaire was originally framed into eight themes or domains (see Appendix E for the first draft questionnaire):

A. Awareness, history and motivation for giving feedback about GPs (if any)

Study B found that half of the participants were not aware that they could leave feedback formally for their GP. This domain explored whether patients were aware that they could give formal feedback about GPs and whether they had given such feedback about a GP or GPs in the past. It also explored why some patients had not given feedback about GPs. Although the level of awareness of OPF websites had been measured by Galizzi et al. (2012), previous research had not explored the level of awareness of other feedback mechanisms and patient motivation for their use. Findings from Study B in relation to patient motivation for not giving feedback were used to devise the items on the scales.

B. Consideration of giving feedback about GPs in the future, why and when?

Study B found that the majority of the participants had not given feedback formally before about their GP, therefore the questionnaire from now onwards focused on patient consideration for giving feedback in the future. Therefore, in this domain, patients were asked whether they would consider giving feedback about their GP in the future and why. Study B also found that almost all patients said they would give

feedback about their GP when they experienced an extreme negative experience; this was explored in this domain to ascertain whether it was true.

C. Preference on mode of feedback

There are various ways that patients can leave feedback about GPs. This domain explored which method was most preferred by patients, based on the list of methods that were found to be most popular in Study B. Study B found that patients would choose a different method based on whether they wanted to report positive or negative feedback, therefore both areas were explored. The previous study also found that patients preferred to leave feedback about their GP with the GP practice rather than a third party. This was also explored in this domain.

D. Awareness and consideration of the use of OPF

This domain focused on OPF websites. The level of awareness and consideration of use of OPF or doctor rating websites had been measured by Galizzi et al. (2012). However, based on findings from Study B, this domain went a step further and explored what may have motivated patients to use an OPF website, and also what may or may not motivate patients to use OPF websites in the future. Although the latter was explored by Patient Opinion on their own users in an unpublished survey (Patient Opinion 2015a), Study B findings were used to adapt the questions and scales, and select only the relevant options.

The use of an app by patients in England to give feedback had not been explored in previous research, although Bidmon et al. (2014) explored what factors may affect people in Germany to use and adopt doctor rating apps. Study B found that patients in England may well prefer to use apps to give feedback about their GP, rather than give it through a website using their computer. Therefore, this was explored in this domain too.

E. Feedback in public or private

Study B found that some patients may prefer that feedback goes directly to the GP practice, and not online or in the public domain. This domain will explore the extent to which this is true.

F. Anonymity and privacy

Anonymity and privacy were two important concerns that participants raised in Study B and GPs raised in Study A, therefore these were explored in this domain. Patients were asked whether they were happy to leave their real name in public (online) and privately when they leave feedback about their GP, and also whether they would like to name their GP when they leave feedback about him or her, both publicly and privately.

G. Other factors that may be affecting patient intention to give feedback about GPs

Three other factors that may be affecting patient intention to give feedback to their GP, whether online or though other methods were explored in this domain. One participant mentioned in Study B that if she was seeing the GP more often than once a year, she was more likely to give feedback about her GP. The frequency of visiting a doctor as a dimension was also explored by Emmert et al. (2013a) in relation to OPF in Germany, and in this domain, participants were asked whether they had a long term condition, as this would imply a higher frequency of visits to the GP. The use of the internet for health information was measured by Galizzi et al. (2012), and this was measured in this domain using the same item and scale. An additional question was asked about how many GPs there were in the patient's GP practice; this was to ascertain whether it is true that patients who have the freedom to see a different GP within a GP practice are more likely to be critical of their GP, as findings from Study B suggested.

H. Socio-demographics

In this domain, gender, age, education, annual household income, and region of residence in England were measured to ascertain whether there was an association between any demographic factors and patients' views on giving feedback about their GP. The questions that participants were asked on gender and region of residence were derived from the English national census (Office for National Statistics 2011); age was derived from the Workplace Employee Relations Survey, 2004 (Department of Trade and Industry 1998); education was derived from the Opinions and Lifestyle Survey, 2013 (Office for National Statistics 2013b); and annual household income

from the British Election Study Continuous Monitoring Survey, 2008-2010 (Sanders and Whiteley 2014).

Use of the term 'doctor rating website' instead of 'OPF website' – The decision was made to use the term 'doctor rating website' instead of 'OPF website' in the questionnaire. This was because the former term was perceived to be easier to understand by the general public, and this was also confirmed by the patients who assisted in the design of the questionnaire (see section 7.6.1), and expert reviewers (see section 7.6.2). The term 'doctor rating website' was also used by Galizzi et al. (2012) in their questionnaire on OPF websites (which was implemented in London).

7.4 CONCEPTUAL FRAMEWORK FOR QUESTIONNAIRE EVALUATION

The total survey error paradigm was introduced by Biemer and Lyberg (2003b) as part of the total survey quality, introduced to identify potential sources of error in the design, collection, processing and analyses of survey data. This paradigm can be used to optimise survey quality within the parameters of given resource constraints (such as design and cost). It was praised by Groves and Lyberg (2010) as a conceptual foundation in the field of survey methodology, but was criticised for being exclusively an intellectual paradigm rather than a statistical model of survey error. The paradigm was then adapted by Pennay (2014) using work from both Groves et al. (2009) and Biemer and Lyberg (2003b) to create the Total Survey Error framework (TSE), which is described as the survey life cycle from a total survey error perspective. The TSE she argues provides both a theoretical and practical framework for all aspects of survey design and evaluation, and can be used by researchers as a tool to assess, evaluate, and improve survey research practice (Whiteley 2015).

The TSE Framework (as shown in Figure 7-1) consists of both errors of representation (sampling errors) and errors of measurement (non-sampling errors). The former occurs as part of the selection of the sample from the sampling frame. The latter occurs when designing and conducting the survey. All of these errors need to be minimised as far as possible in survey research. This conceptual and practical framework – the TSE – was used as a foundation in this phase (of developing and validating the questionnaire) to assess and reflect on improving the quality of the questionnaire and its results, and to reduce the possibility of any errors.

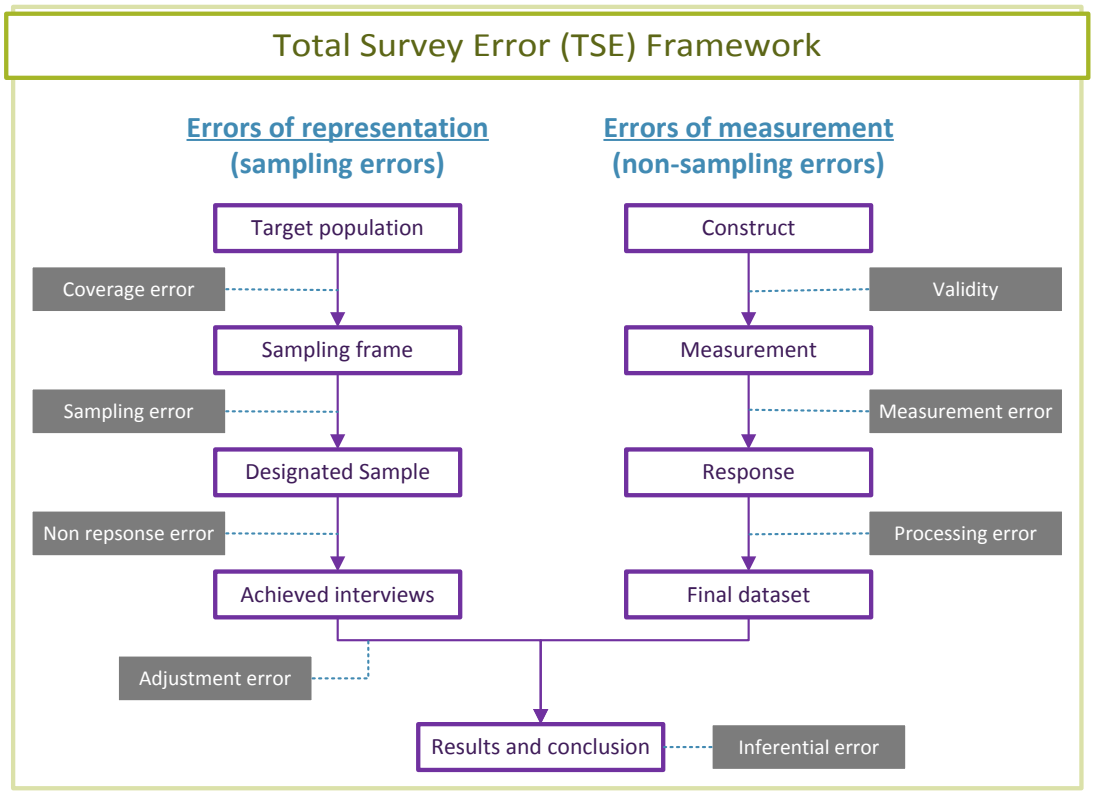


Figure 7-1: Total survey error framework (the survey life cycle from a Total Survey Error (TSE) perspective). Adapted by Pennay (2014) from Groves et al. (2009) and Biemer and Lyberg (2003b).[7]

7.5 QUESTIONNAIRE MODE AND REDUCING SAMPLING ERRORS

The aim of Study C (in Chapter 8) was to get a representative sample of responses from the public in the UK using a population questionnaire in a cross-sectional design. Population questionnaires can be conducted with the public using various modes, and each mode has its strength and limitations, as illustrated in Table 7-1. Deciding which mode to use for this questionnaire was challenging because of the difficulty in getting a truly representative sample within the budget constraints. Various experts were consulted for advice between the period of Aug 2015 to Nov 2015, including five senior academics with experience of conducting large scale population questionnaires, and approximately nine market research companies.

Telephone based questionnaires were not appropriate because the response scales for some of the questions were more than seven, and such lengthy scales would be

[7] Explanation of terms: "Constructs are elements of information sought by the researcher. Measurements are more concrete and are often the questions posed to the respondent. Response is the data produced from measurement, and sometimes this data needs editing, outlier detection for example or processing data so it could be used for placing ages into age groups." (Groves et al. 2009).

difficult for the respondent to understand, follow and select over the telephone. Online panel questionnaires were also not appropriate because they would exclude all members of the public who do not have access to the internet (Duffy and Smith 2005), especially important because this questionnaire's focus is online feedback. Online panel questionnaires are also based on self-selection, which means they would not give representative results because they would introduce non-coverage bias (Callegaro et al. 2015; Gideon 2012).

Sending postal surveys using a random sample may have been appropriate; however, the response rate to postal questionnaires in the UK is and has been very low. Although Casiday et al. (2006) received a 36% response rate in 2006 to their survey on parental attitudes to the MMR vaccine in one primary care trust, Foxcroft et al. (2015) found that response rates to their 30-item General Lifestyle Questionnaire in a primary care trust was only 7%. As this questionnaire had over 50 questions, the response rate may have been even lower, and this was also the consensus of six research based companies who were made aware of the research aims and the survey length, and who had ample experience of conducting postal questionnaires. The low response would have introduced serious bias to the data, and the benefit of conducting a random sample would have been eradicated (Edwards et al. 2002; Nulty 2008). This is because with a low response rate, respondents may be different from non-respondents in characteristics. The non-response bias would therefore affect the reliability of the questionnaire's population estimate, and would weaken the generalizability (external validity) of the results of the questionnaire (Bowling 2005; Edwards et al. 2002; Gideon 2012; Nulty 2008). Furthermore, Kennedy et al. (2016) argue that a low response rate for a probability based survey needs as much adjustments and modelling as those used with non-probability samples to produce accurate reliable estimates.

According to Gideon (2012), there is some agreement that face-to-face surveys have the highest response rates, followed by telephone surveys, and then postal surveys. Therefore, face-to-face surveys were considered for this research. Face-to-face surveys can be conducted using a random sample by The Office for National Statistics in the UK and this would have been ideal; however, they are extremely expensive to conduct and were beyond the budget for this research. Consequently, the best option available after a random sample was to conduct the questionnaire using random location quota

sampling and this is what was used (see section 8.3.2). This is not as a good as a random sample (Grenfell et al. 2011); however, market based researchers and some academics (including Jones et al. 2011; Low et al. 2013; Power et al. 2011) argue that it can produce results that are representative of the population in England (see section 8.3.2 for details about the sampling procedure). Although it may have been useful to mix modes to address the bias of one survey mode (for example, postal survey alongside face-to-face random location surveys), this was not feasible due to budget constraints.

Face-to-face questionnaires are also the least burdensome method because they only require the respondent to speak the same language in which the questions are asked, and no reading skills are required (Gideon 2012). It also has a higher item response, because if respondents struggle to answer a question for example, the trained interviewer can explain; and with longer questionnaires the interviewer can keep the respondent motivated, and probe for responses (Gideon 2012). Furthermore, premature termination (where the respondent does not complete the questionnaire) is less likely to happen in the presence of a motivating interviewer, and the interviewer has more control over the situation and can ensure that all questions are answered, and responses are recorded correctly (Gideon 2012). The advantage of using CAPI (Computer Assisted Personal Interview) during a face-to-face questionnaire is that questions that are not relevant to the respondent can be skipped through complex routing and skipping instructions, and responses can be recorded in real-time. Furthermore, scales can be randomised to reduce response order bias, and digital images and videos can also be shown where appropriate.

However, the disadvantage of face-to-face questionnaires, even when conducted by trained interviewers, is that they may not have subject knowledge or understanding of the topic. This was not an issue for this questionnaire because the topic area and questions were self-explanatory. Another disadvantage of face-to-face questionnaires is that there could be a slight bias of social desirability in attitudinal questions, and highly sensitive questions may not be suitable. The former problem was addressed by asking indirect attitudinal questions, and the latter was not applicable to this questionnaire.

It was not feasible for the researcher to personally conduct 800+ interviews of the public in the UK using a random location quota sampling method; therefore, eight

survey research agencies were contacted for quotes during Sep-Oct 2015 to conduct the questionnaire with a representative sample of the public in England. Based on discussions with the companies, the available budget, and previous experience of academic colleagues, a leading independent survey agency was chosen, Ipsos MORI, to conduct the face-to-face questionnaires with the public in England, using CAPI and random location quota sampling methodology (see section 8.3.2). Ipsos MORI is the second largest research company in the UK, and it is also the agency that conducts the national GP Patient Survey, on behalf of NHS England and the Department of Health, and it is therefore well experienced in conducting research in general practice.

Table 7-1: A summary of advantages and disadvantages of different survey modes (Based on the literature and consultation with academic survey experts and market research survey experts)

Survey Mode	Sampling type	Advantages	Disadvantages
Postal survey	Random sampling	• Participants selected through a random sample using the PAF (Postcode Address File) • Less bias towards social desirability in attitudinal questions • Participants can fill in the questionnaire when it suits them	• Response rate is estimated to be very low (around 10% for this survey), therefore results will not be representative of the population, which defeats the advantage of selecting through a random sample • Questions have to be limited to around 25-30 questions due to respondent fatigue • A postal survey excludes those with low literacy skills • There may be regional or age biases within the data, which you cannot control for, and therefore inter-comparisons within the data may not be possible to do • It is not suitable for complex routing
Telephone survey	Landline numbers randomly selected, until given quota is reached. Uses a form of quota sampling	• The results may be representative, depending on the response rate, and whether there are regional or age biases (this is difficult to predict with accuracy before the survey is conducted) • It does not exclude those participants who are not online or have low literacy skills	• It is not a suitable method with one A4 side information leaflet and the need to explain the topic over the phone • It excludes those who do not have a landline telephone, those who cannot speak English, and those who have speech or hearing impairments • It is not suitable for multiple scales on questions or complex scales
Online survey panel	Random selection from a pre-recruited online panel. Uses a form of quota sampling	• The results give representative quotas, on age, gender and region. So one can confidently do inner comparisons between respondents • Little bias towards social desirability in attitudinal questions	• This method excludes those people that are not online, and also the many millions of people who have not joined the online panel. To claim generalizability of results would be highly questionable
Face-to-face random location survey	Random location quota sampling, a form of quota sampling	• It uses a random location quota sampling method which ensures that participants are selected from random locations across the UK, and are representative in given quotas, such as age, gender and region • The questionnaire can be lengthy as the interviewer can keep the respondent engaged • This mode does not exclude those who are not online, those who do not have a landline telephone, those who cannot speak English, and those who have speech or hearing impairments • It is much cheaper than a face-to-face random sample survey	• It is not a truly representative sample because although the locations are randomly selected, individual participants are not selected randomly (further details about the method is in section 8.3.2) • It excludes those people who are not at home • There could be a slight bias towards social desirability in attitudinal questions • It may not be suitable for highly sensitive questions
Face-to-face random sample survey	Stratified Random sampling	• It has the advantages of a face-to-face survey (mentioned above) • The difference is that the results are truly representative of the population in England, with a randomly selected sample using PAF, and a response rate of around 60%	• It is extremely expensive to conduct, with an estimated cost of £80,000 for 25 questions (Office for National Statistics Omnibus Service) • There could be a slight bias of social desirability in attitudinal questions • It may not be suitable for highly sensitive questions

7.6 EVALUATION METHODS USED TO REDUCE NON-SAMPLING ERRORS

In this section, the focus is on methods and techniques used for evaluating non-sampling errors in survey work (as illustrated in Figure 7-1), specifically validity and measurement errors (Biemer and Lyberg 2003a; Groves et al. 2009; Pennay 2014). Validity refers to the extent to which a construct (elements of information sought by a researcher) is adequately captured; this is sometimes referred to as a specification error. This is usually a high level error, whereas the measurement error is the extent to which a measure (for example a question posed to the respondent) accurately captures the construct. The measurement error could be related to i) the questionnaire (poor questionnaire design), ii) the respondent (they could provide inaccurate answers due to misunderstanding or not understanding the question); iii) the interviewer (poor interviewing technique); or iv) the mode of the questionnaire (for example, primacy effects are more commonly associated with paper-based self-completion surveys). The processing error refers to errors when inputting the raw data or computing new variables. This will be addressed in the next chapter.

To minimise the validity and measurement errors of the new questionnaire designed by the researcher, the questionnaire underwent seven stages of thorough evaluation. These stages have been summarised and depicted in Figure 7-2. The forthcoming sub-sections describe each of the evaluation and validation processes in further detail.

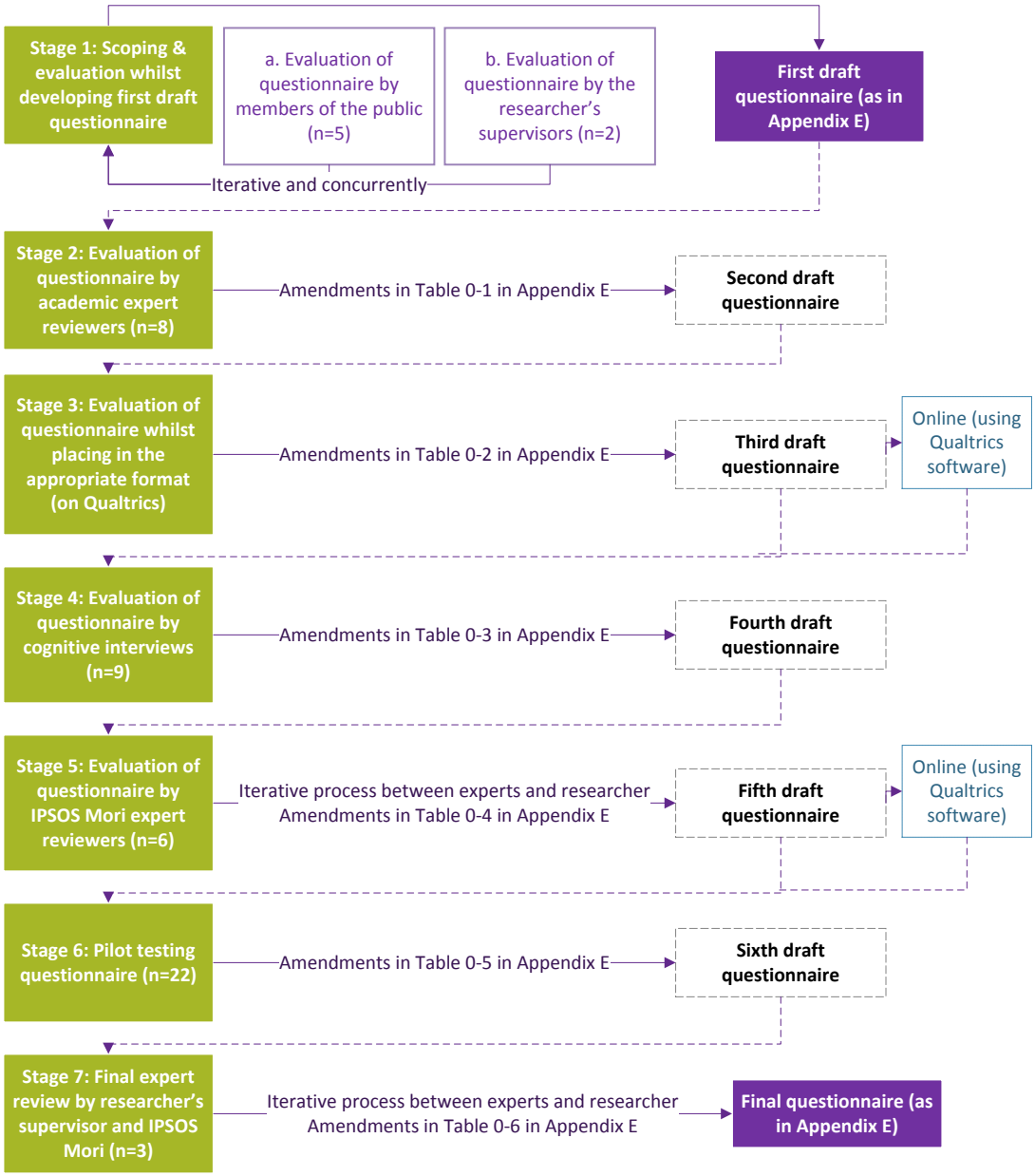


Figure 7-2: A summary of the seven stage evaluative process used to validate the questionnaire

7.6.1 Stage 1: Evaluation whilst developing the first draft questionnaire

The first draft questionnaire (see Appendix E) covered all the domains mentioned in section 7.3, and was designed to be clear, concise and easy for a lay person to follow. The question type and scale of measurement were different for each question, depending on what was most appropriate, and for some of the questions, the scale of measurement was derived from the findings of Study B. The content and wording of each question and its scales were revised iteratively at this stage by the researcher (with ten versions of the questionnaire). The researcher's two supervisors and five members of the public were also regularly consulted. The questionnaire was then

tested on these five members of the public (who were all likely respondents). They were asked to fill in the questionnaire on paper in the researcher's presence, and then give feedback about: i) any problems they encountered with the questions or scales, ii) any terms or questions they did not understand, iii) any questions or scales they found difficult to answer, iv) the length of the questionnaire, v) the sequence of the questionnaire, and vi) any other suggestions to improve the questionnaire or make the questionnaire easier for the layperson to understand. The researcher also looked out for visual cues, such as sighs, looks of confusion or struggle.

Feedback received from this stage of testing with the public resulted in helping the researcher conceptualize, contextualise and frame questions appropriately. Specific major changes included: reducing the length of the questionnaire by combining some of the questions together; removing 8 questions, some of which were repetitive; and amending the wording on a few questions. The questionnaire was also reviewed by the researcher's two supervisors, and similar changes were made based on their suggestions.

There were 43 questions (items) when the first draft questionnaire was finalised (see Appendix E). An introductory section was included at the beginning of the questionnaire which explained the purpose of the survey. The questions in the questionnaire, as well as the research questions they link to and the statistical tests proposed for use were also checked and approved by an academic statistician in early Nov 2015 (see Appendix E for the analysis plan).

7.6.2 Stage 2: Expert reviews by academics

In order to evaluate the measurement or observation error of a survey, Groves et al. (2009) and other survey researchers recommend the use of 'expert reviews' as the first step to validate the questionnaire (DeMaio and Landreth 2004). Expert reviews are where both questionnaire design experts and subject matter experts evaluate the content, cognitive, and usability standards of a questionnaire (Groves et al. 2009). This can highlight any problems the questions and scales may have in relation to its scope for example, or the way the questions may be understood or perceived by its participants, and evaluate whether the questions are clear and easy for participants to understand and answer (DeMaio and Landreth 2004; Groves et al. 2009).

The first draft questionnaire was sent through email in 'Word format' to eight academic expert reviewers (from four UK based universities) in Nov 2015. They were asked to review the questions and scales, but not the physical formatting of the questionnaire. All of the experts were questionnaire design experts and three of them were also subject matter experts (in digital health). Fourteen changes were recommended by the reviewers and 13 changes were made (see Table 0-1 in Appendix E for the list of the changes). The questionnaire was then revised to produce a second draft questionnaire.

7.6.3 Stage 3: Evaluation of questionnaire whilst placing in the appropriate format

The questionnaire when implemented with the general public was conducted using CAPI (Computer Assisted Personal Interviewing) methodology (as mentioned previously in section 7.5). It was therefore necessary to place the questionnaire in the appropriate format before formally testing with the public. Therefore, the questionnaire was placed into software called *Qualtrics* which creates online surveys, and is similar to the software that was used in the implementation stage by Ipsos MORI (see section 8.3.3). The questionnaire was published online but the web link was kept private for the researcher's use only.

During the process of placing the questionnaire online, the questionnaire underwent further evaluation, and nine changes were made to the questionnaire (these have been detailed in Table 0-2 in Appendix E). This resulted in the formation of the third draft questionnaire. This step as an evaluation was not anticipated, however, the process of converting the questionnaire into the appropriate format meant that a few problems were identified, which were rectified before testing the questionnaire with the public in the next stage.

7.6.4 Stage 4: Cognitive interviews

Cognitive interviewing is a process in which participants respond to draft survey questions, and are asked to reveal their thought processes at the same time (Farrall et al. 2012; Priede and Farrall 2011). The premise is that knowing these thought processes and cognitive understanding can help the researcher evaluate the quality of the survey questions and responses. Furthermore, it can reduce response error because it can help identify any difficulties or problems that cannot be identified

through statistical methods (Miller 2011; Osborne et al. 2006; Willis 2004). According to Levine et al. (2005) and Willis and Artino (2013), there is a growing body of literature that demonstrates that only a very few cognitive interviews can allow for the identification of problems with questions, and help in making revisions, so that the quality of the survey data can be greatly improved.

Cognitive interviewing has evolved and grown since its first use in 1984, and now there are two ways cognitive interviews are conducted: thinking aloud and verbal probing (Priede and Farrall 2011). In the former, the respondent is asked to vocalise his or her thought process as he or she is filling in the questionnaire. The researcher then reads or listens to the transcript to understand the respondent's thought process and understanding, and uses this to remove or change any difficult questions or phrasing. In the latter, the researcher takes a more active role, and respondents are probed with questions to get a better and deeper understanding of their thought processes.

To evaluate this questionnaire, the verbal probing method was used alongside the thinking aloud method to detect potential sources of response error. This is because when the thinking aloud method is used on its own, Priede and Farrall (2011) argue that useful information is not always gained, since although it can highlight that there is a problem with a question, it cannot always tell you what the problem is. Furthermore, some participants may find it difficult to think aloud, but more importantly, in this questionnaire, there were certain phrases like 'doctor rating website' and 'feedback about GP', which the researcher anticipated respondents needed to be asked about, to ensure that participants' understandings of such terms were correct and consistent. Therefore, respondents were asked to think aloud when answering questions, but were also probed with further questions.

Topic guide for cognitive interviews – Once the third draft questionnaire was ready, a topic guide was developed by the researcher. The topic guide (see Appendix E) detailed the way the interview would be introduced to the participant, an explanation of thinking aloud in simple terms, and the anticipated probes. During the interview however, spontaneous probes, conditional probes and emergent probes were also used, as described by Priede and Farrall (2011). For example, if the participant took a long time to answer a particular question, a conditional probe was

used: they were asked why, and probed further to ascertain if there was a problem with the question.

Participants and interview procedure – A purposive sample was used to ensure participants were from different age groups. Therefore, eight volunteers from London and the North West who were between the ages of 18 and 59 took part in the cognitive interviews in Dec 2015. Willis and Artino (2013) argue that as few as 5 or 6 participants can provide useful information to improve survey questions, and this was true for this questionnaire too.

Participants were sent an invitation letter and information sheet beforehand through email (see Appendix E), and consent was taken from all participants at the beginning of the interview. Participants were interviewed face-to-face using the topic guide and the 'online questionnaire' on the researcher's laptop. The researcher sat next to the participant, read the question aloud, and showed the participant the scales or possible responses. The researcher inputted the response into the online questionnaire. The interviews were recorded digitally using an app called *iTalk*, and they had a mean average of 20 minutes in length. The interviews took place in the participants' homes or at a public café.

Analysis of the cognitive interviews – Each recording of the cognitive interview was listened to and a summary was prepared in an Excel sheet, which contained a list of responses to the probes, and any other problems that could be identified. This determined whether the interview provided evidence of a 'definite problem', 'possible problem', or 'no evidence of a problem' in relation to each item in the questionnaire, which was followed by a written explanation of the reasons for this judgement (as done by Levine et al. (2005)). These summaries were then combined under each question, and based on that it was decided whether the question needed modification, removing, changing or leaving as it was. Any additional areas mentioned or discussed were also noted down.

Results and changes made to the questionnaire – 23 problems were identified with the questionnaire from the cognitive testing, and 22 changes were made as a result of this. These problems and the resulting changes made are outlined in Table 0-3 in Appendix E. These changes resulted in the formation of the fourth draft questionnaire.

7.6.5 Stage 5: Expert review from Ipsos MORI

The fourth draft questionnaire was then sent to questionnaire expert reviewers at Ipsos MORI. The questionnaire was reviewed by 6 expert reviewers, and it was transformed into the format that matched the Ipsos MORI CAPI system and the face-to-face interview style that Ipsos MORI uses. At this stage, the questionnaire was revised iteratively by the researcher and the Ipsos MORI team (there were five iterations). 16 major changes were made as a result of these reviews and discussions, and these are listed in Table 0-4 in Appendix E (minor changes to wording are not recorded in the table). These changes resulted in the creation of the fifth draft questionnaire.

7.6.6 Stage 6: Pilot testing the questionnaire

Pilot testing a questionnaire can ensure that any possible flaws or errors in the questionnaire are detected. It can also help identify ambiguous items, and the non-verbal behaviour of respondents can provide information on any uncomfortable or difficult questions in the questionnaire (van Teijlingen and Hundley 1998). Therefore, in January 2016, the fifth draft questionnaire was placed online using the *Qualtrics* software and piloted using the CAPI method with 22 volunteers (aged between 18 and 72) from North West and London. The aim of this stage of piloting was to improve the internal validity and reliability of the questionnaire, because the questionnaire had been amended since the cognitive interviews were conducted in December 2015.

Participants were sent an invitation letter and a participant information sheet beforehand in person or through email (see Appendix E). Consent was taken on the online screen (see Appendix E), before the face-to-face interview started. The interview lasted around 10-15 minutes. Based on the results and experience of pilot testing, twelve changes were made to the fifth draft questionnaire (as listed in Table 0-5 in Appendix E), which resulted in the formation of the sixth draft questionnaire.

7.6.7 Stage 7: Final expert review

In late January 2016, the sixth draft questionnaire was then reviewed by the researcher's supervisor for the final time, as well as three senior expert reviewers at Ipsos MORI, one of whom was a director who specialised in health research. They

suggested ten changes to the questionnaire, which are detailed in Table 0-6 in Appendix E. These changes were made, and this resulted in the seventh draft questionnaire, which was also the final version of the questionnaire. This final version can be found in Appendix E.

7.6.8 Strengths and weaknesses of the validation methods

Multiple methods were used to evaluate and validate the questionnaire in this phase of the research to reduce specification and measurement error and ensure validity of the questionnaire. Amongst the methods were multiple expert reviews from questionnaire experts both in academia and in the polling industry, subject experts from academia and the healthcare industry, and the researcher's supervisors. Furthermore, the questionnaire was reviewed and evaluated by the public from the very initial design stage, and further validation was conducted with the use of cognitive interviews and piloting. In total, the questionnaire was reviewed by 55 individuals before it was considered validated.

It must be acknowledged however that the questionnaire was only piloted on 22 members of the public using a convenient sample, because by this stage of the validation, no problems were being identified by the participants, and there was no apparent benefit in conducting further piloting. During the piloting phase, statistical analysis was not used to validate the questionnaire for internal validity or consistency, because multiple questions were not measuring the same construct within the questionnaire, and therefore conducting for example factor analysis was not appropriate.

7.7 SUMMARY

The questionnaire was developed based on the findings of Study B and literature related to OPF. Prospective participants were involved even at the initial design stage. Once the first draft questionnaire was ready (a copy of which is in Appendix E), the questionnaire then underwent thorough evaluation through multiple phases of expert reviews, cognitive interviews and pilot testing with prospective participants. The changes made at each stage have been documented in tables in Appendix E. The final validated population questionnaire can be found in Appendix E, and this version was implemented in Study C (see Chapter 8).

CHAPTER 8 - STUDY C (PHASE 4): MEASURING AND UNDERSTANDING PUBLIC AWARENESS, USAGE AND ATTITUDES TOWARDS OPF

8.1 INTRODUCTION

This chapter reports on Study C (Phase 4) of the research, where a cross-sectional design was used to implement the mixed methods questionnaire with a representative sample of the public in England. The questionnaire was designed and validated in Phase 3 of the research (Chapter 7), and its aim was to measure public awareness, usage and attitudes towards the use of OPF websites to give feedback about their experiences of receiving care from GPs. As reported in Chapter 3, no prior study could be found in the literature that explored fully public views and attitudes towards OPF websites in England.

8.2 OBJECTIVES

The objectives of this study were to use the mixed methods population questionnaire designed and validated in Phase 3 in order to:

(1) Quantitatively and qualitatively assess the views of the general public in England on giving feedback (online and using other methods) about their experiences of care from GPs. This included exploring public awareness and experience of giving feedback; their reasons for not giving feedback to date; their consideration for giving feedback in the future; and their motivation and preference for giving feedback.
(2) Understand how much value, if any, the public holds for OPF websites (or doctor rating websites).
(3) Assess whether the public have any concerns about OPF websites.
(4) Assess whether public attitudes differ for giving feedback online and using other methods.
(5) Evaluate whether public views differ according to particular demographics, lifestyle, and health status.

8.3 METHODS

8.3.1 Questionnaire design and mode

The mixed methods questionnaire designed and validated in Chapter 7 was implemented in this cross-sectional study. The questionnaire used a convergent parallel design, which meant that qualitative and quantitative data were collected in parallel, analysed separately and then merged (Creswell & Clark, 2011). The quantitative data was collected primarily to understand public views on giving feedback about care from GPs (both online and using other methods), and the qualitative data helped explain the quantitative data. The two forms of data together generated greater understanding and insight of the topic area.

Section 7.5 in the previous chapter explained in detail why a face-to-face questionnaire was chosen as the most suitable mode to conduct this study, and why Ipsos MORI was chosen as the vendor that implemented the questionnaire with a representative sample of the public. In brief, face-to-face was the most appropriate mode because of the length of the questionnaire, it was within budget, and it is also least burdensome on the respondent. Ipsos MORI was chosen because they are a reputable and well experienced research company, who also conduct the national GP Patient Survey on behalf of NHS England (and the Department of Health).

8.3.2 Sample size and sampling procedure

Sample size – An a priori target sample size of 850 members of the public (in England) was set based on guidance from Field (2013) to allow prevalence statistical estimate proportions to be within 3.5% confidence interval with 95% confidence level. Ipsos MORI also confirmed that approximately 850 respondents were sufficient to get a representative sample of the population in England. A post-hoc sample size analysis illustrated that the prevalence data was within a confidence interval of 3.37% with 95% confidence level.

Sampling procedure – Random location quota sampling using quotas for age, working status, gender and tenure within region were used in this study. There were two stages to the sampling. In the first stage of sampling, approximately 180 Local Area Authorities were randomly selected from all those in the UK, some of which were in Scotland and Wales and therefore do not feature in this study. In the second

stage of sampling, one Output Area (a small area made up of around 60 to a 100 addresses) was randomly selected from each of the Local Area Authorities selected in the first stage. These were the output areas where interviewers went to conduct the interviews with the public.

Interviewers (n=155) were given quotas of people to interview for each Output Area according to age, working status, gender and tenure within region. Interviewers went door to door and invited the person who answered to take part, as long as they were aged 15 or over. If they refused, interviewers invited another member of the household to take part. The visits were spread out during the week, including evenings, Saturday and Sunday to ensure inclusion of people who work in the day time. Interviewers kept a gap of three doors between every successful interview to avoid interviewing immediate neighbours, and to minimise clustering of interviews.

8.3.3 Data collection procedure

An omnibus survey is where more than one survey on a topic is conducted during the same interview so that costs can be divided across clients (Gideon 2012). The questionnaire from this study (which was around 10 minutes long) was included in the Ipsos MORI Face-to-Face Omnibus survey called Capibus, which runs every week and is around 30 minutes long. The questionnaire was about half way through the Capibus survey, and the other topics on the same Capibus were finance, energy and printers. Ipsos MORI confirmed that none of the other topics would have influenced responses to this (the researcher's) questionnaire.

At the start of this questionnaire within the Capibus, a clear introduction was provided (see Appendix E). The introduction highlighted that questions about 'feedback' referred to reviews, ratings, comments, and complaints, both positive and negative. The introduction also clarified that all of the questions refer to giving feedback about experiences of receiving care from GPs only, and not any other healthcare professional. Respondents were additionally provided with an information sheet about the research (see Appendix F).

Ipsos MORI used the CAPI methodology to conduct the interviews (as detailed in Section 7.5 of the previous chapter). Therefore, once the final questionnaire was ready (see Appendix E), Ipsos MORI placed the questionnaire into their system, which was then loaded onto their interviewers' laptops (see Appendix F for a sample

of laptop screenshots of the questionnaire). Prior to loading, the script was tested by six people at Ipsos MORI to ensure that all filtering, randomisation, and wording was correctly inputted and understood by the system. The filtering was also tested by Ipsos MORI dummy software to ensure the filtering was accurate and responded correctly to all of the different possible options an interview could take.

The face-to-face interviews using the questionnaire were conducted by 155 trained interviewers using the CAPI methodology in people's homes (not on doorsteps) from 29th January 2016 to 10th February 2016. Informed consent was taken verbally from all respondents before entering their homes.

During the interview, respondents were asked questions by the interviewers, and the interviewers immediately noted down each response on to their laptops. Results were collated in real-time and recorded centrally by Ipsos MORI. Open ended questions were typed by the interviewer verbatim. A 'show-card' (in Appendix F) was shown for question TY15, because the scale was lengthy. Respondents always had the option to refuse to respond to any of the questions, and this was noted down as a separate code if they did.

8.3.4 Validation of interview data

The ISO 20252 guide (Blyth 2012) dictates that 10% of all interviews should be validated (back-checked) on each project, and that interviewers should be validated on a regular basis. This guide was used to validate the interviews. Consequently approximately 13% of the respondents were selected for validation before the whole project was validated.

The validation process was managed by a team in the Harrow Field Ipsos MORI Office with validations carried out using Computer Assisted Telephone Interviewing within Ipsos's telephone centres. Respondents were contacted by a specially trained team of validators, and the attributes of the interviewer, such as politeness and professionalism, were first checked. Thereafter, specific questions from the questionnaire and key demographics were asked to ensure that responses were recorded accurately. 10% of all the validations were monitored by a supervisor. If there was doubt over an interview or interviewer's quality, personal face-to-face validations would have been carried out by an Ipsos MORI regional manager or supervisor. However, this was not required for this study.

8.3.5 Data preparation

The data captured was provided to the researcher in a SPSS file and Excel files. There was no missing data because the computer programming of the script ensured all respondents answered the relevant questions.

Weighting the quantitative survey data – Weighting is a technique commonly used to 're-ascribe' respondent records in a survey data file to compensate for known biases, such as non-response, non-coverage and sampling errors (Bradley 2006). This is done by applying a weight, which is a multiplying factor (less than one or greater than one) to some or all respondents so that the relative importance of all respondents in the final data collected is not equal (Sharot 1986), and the survey is 'calibrated' to ensure balance (Bradley 2006). A survey can contain multiple weights, and the purpose of applying weights is that the survey represents as closely as possible the sample 'profile' of the population of inference (usually in demographic or regional terms) (Kalton and Flores-Cervantes 1998).

There are different types of weighting methods (Kalton and Flores-Cervantes 1998), and according to Sharot (1986) and Bradley (2006), the main ones are cell-weighting and rim-weighting. In the former, the variables sex, age and region each form a cell, and then a weight is calculated so that each cell achieves its target. The latter uses computer power, where each variable is addressed one by one, and a number of solutions are run until a best fit is achieved. The latter is therefore argued to be superior to the former, and it is used across the market research industry, including Ipsos MORI, to weight survey data (Bradley 2006; Sharot 1986).

The sample profile produced for this study was similar to that achieved on The National Readership Survey (NRS)[8], which uses random probability sampling. Therefore, using rim-weighting, only a very small corrective weighting was applied (on gender, age, social grade, region, working status, tenure and ethnicity) by Ipsos MORI to adjust the final results to make them in-line with the national demographic profile. This was so that any minor deficiencies or biases in the sample could be corrected and to ensure that the sample was as close to a nationally representative sample.

[8] The National Readership Survey (NRS) is a random sample survey that provides estimates of the number and habits of people reading print media in the UK.

In practice, this meant that using the National Readership Survey and the latest Census data, Ipsos MORI explored what the profile of a nationally representative sample of adults aged 15+ in England should be. They then produced target weights from these sources based on the following rims (provided in Appendix F): gender within region, gender within social grade, gender within age, gender within working status, and tenure and ethnicity. These targets were then set against the profile they actually achieved (the unweighted sample) and then the programme ran through a series of iterations in order to get the best fit to match the target weights. At the end of this process, each cell was given a weight. So for example, men in one region may have been down-weighted slightly, so given a weight of 0.907232; and men in another region may be up-weighted slightly, so given a weight of 1.174015. The respondents are all still there, but their responses may be adjusted marginally to have more or less weight. This is a standard industry weighting process and is not unique to Ipsos MORI.

The unweighted and weighted profile data can be seen in Table 8-2, which shows minor differences between profiles. For the responses to the questions on the questionnaire, the overall responses between the weighted and unweighted data varied if at all by only 1% or 2%. So for example, for the question in section 8.4.2 about whether participants were aware of the option to give feedback about their experience of receiving care from a GP, the unweighted data indicated 60.7% said no, and the weighted data indicated 61.3% said no; however both of these round up to 61%.

8.3.6 Data analysis

The data was managed and analysed by the researcher using the data provided by Ipsos MORI, although Ipsos MORI conducted the initial data processing. The statistical raw data was provided in a SPSS file, and the open ended textual raw data was provided in Excel files.

Data analysis plan – A detailed data analysis plan was created from the first draft questionnaire (see Appendix E). The appropriateness of the statistical tests proposed were checked and approved by an experienced academic statistician in Nov 2015. Although some of the questions were modified and combined by the time the

questionnaire was validated and reached the final draft, the majority of the research questions remained the same, and therefore the analysis plan did not need to change.

Statistical analysis – IBM SPSS Statistics 22 was used to conduct the statistical analysis. The sampling weights provided by Ipsos MORI were first applied to the data to correct for known sample biases. Univariate analysis or descriptive statistics was performed to describe respondent demographics, and responses to all other relevant questions. For the purpose of analysis, responses to four questions had less than 8 responses of 'don't know', and these were combined with 'no', to form binary variables (yes and no).

Bivariate analysis was used to describe differences for the main variables (dependent variables, for example, awareness, usage) with respect to the demographic characteristics (independent variables, for example, gender and age). All variables were categorical, and therefore a two-tailed chi-square test (or Pearson's test where appropriate) was used, with a p value <0.05 considered to be statistically significant. The demographic independent variables (for example, gender and age) found to be significant on the dependent variable (for example, awareness) were then included in binomial logistic regression models, which were adjusted manually to determine which demographic factors in combination had a signification association or were predictors for the dependent variable (Marston 2009). Results were presented as odds ratio and 95% confidence intervals, using the format recommended by Peacock and Kerry (2007) for publication. The results for the first binomial logistic regression model and its interpretation presented in section 8.4.2 were checked and approved by an experienced academic medical statistician in March 2016.

Qualitative analysis – All open ended questions were transcribed verbatim by the interviewers, and the data was analysed manually using content analysis. Content analysis is used to analyse textual data (Hsieh and Shannon 2005), with an aim to concentrate on language to classify the text into a number of categories that represent similar meanings, identifying themes or patterns within the data, either through a quantitative or a qualitative approach (Graneheim and Lundman 2004; Hsieh and Shannon 2005).

The content analysis was conducted in three stages. In the first stage, codes were generated manually from each individual response, and the codes found were placed

next to each response in Excel. Frequencies were then counted to measure how many respondents mentioned each code. The codes generated in this first stage were double checked by the researcher to ensure accuracy. In the second stage, the codes (with corresponding counts) were organised, compared and contrasted to form a final frame of codes and categories, with counts being added. In the third and final stage, the categories were condensed, connected and interpreted into themes (and sub-themes were relevant), with counts of the number of respondents who mentioned them still attached to the themes.

8.4 RESULTS

The results of this study are divided into seven sections (see Figure 8-1 for a diagrammatic depiction of the results section). The first section (8.4.1) describes the response rate and demographic characteristics. The second three sections (8.4.2 – 8.4.4) focus on public awareness, past usage and future consideration of giving feedback about the experience of receiving care from GP/s using any method and using doctor rating websites. The final three sections focus on additional factors, which include whether patients are more likely to leave feedback when it is solicited or unsolicited (section 8.4.5), positive or negative (section 8.4.6), and attitudes towards anonymity and privacy (section 8.4.7).

The key results for the second three sections (8.4.2 – 8.4.4) are summarised and presented up front in Table 8-1. The table also summarises the demographic factors that were found to be significant on each of the key dependent variables (using multiple binomial logistic regressions, which will be reported in further detail in the forthcoming sections). The table demonstrates that 15% of respondents were aware of doctor rating websites for giving feedback about GPs, in comparison to 39% of respondents who were aware of giving feedback using any of the method/s. Similarly, 19% of respondents had given feedback about a GP in the past using any method, whereas only 0.36% had given feedback about a GP using a doctor rating website. 76% of respondents said they would consider giving feedback about a GP in the future (using any method); whereas only 18% of respondents said they would consider giving feedback in the future using doctor rating websites. These results as well as explanations for the responses are discussed in detail in their own respective forthcoming sub-sections.

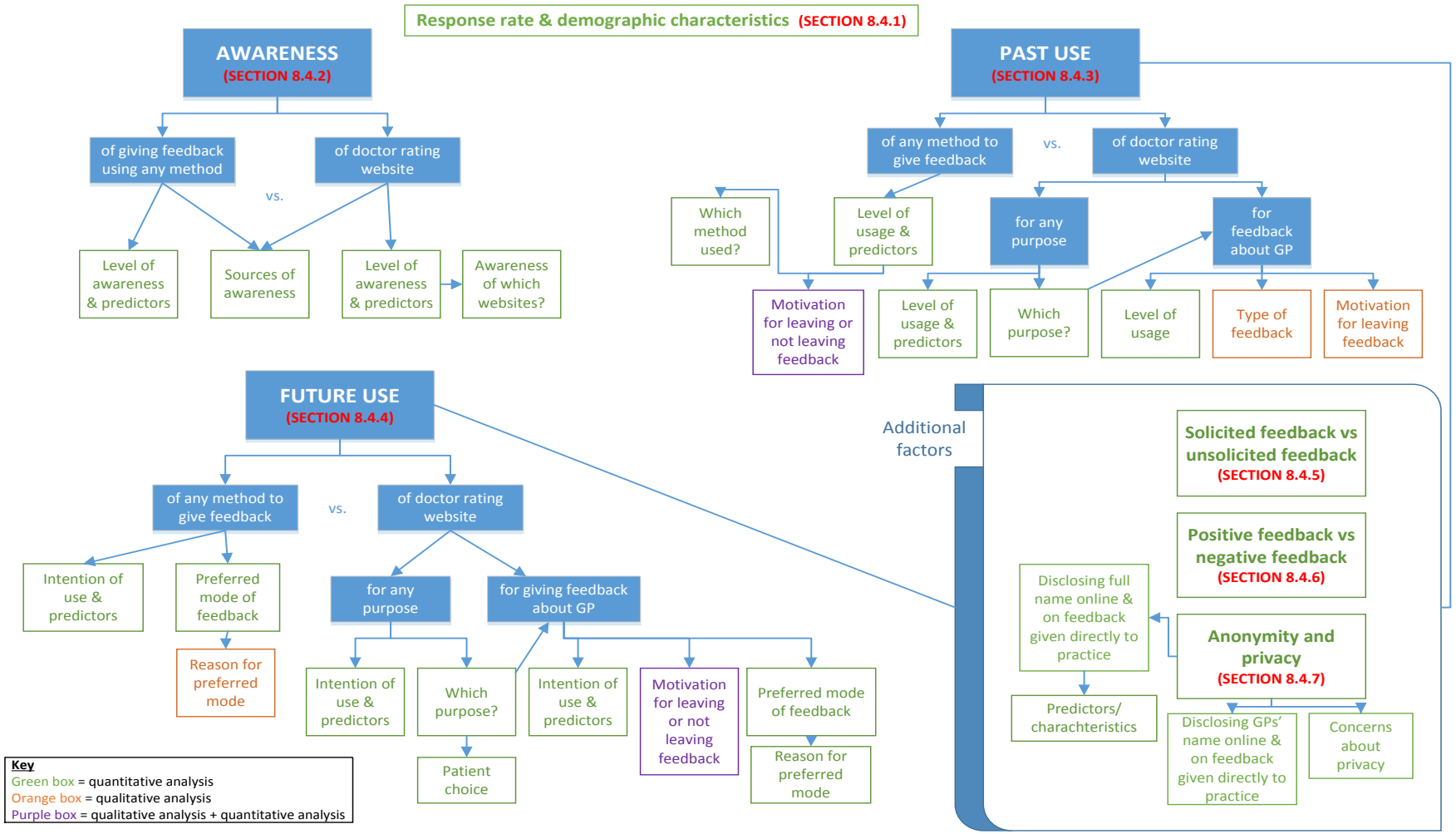


Figure 8-1: Outline of the results section (section 8.4)

Table 8-1: Summary of key results from all respondents (n=844) relating to awareness, past usage and future consideration of use (further details are in the subsections)

	AWARENESS of giving feedback about experience of receiving care from a GP using: **(SECTION 8.4.2)**		**PAST USE** of giving feedback about experience of receiving care from a GP using: **(SECTION 8.4.3)**		**FUTURE CONSIDERATION** of giving feedback about experience of receiving care from a GP using: **(SECTION 8.4.4)**	
	Any method	Doctor rating websites	Any method	Doctor rating websites	Any method	Doctor rating websites
POSITIVE	**39%**	**15%**	**19%**	**0.36%**	**76%**	**18%**
DEMOGRAPHIC FACTORS ***(✓ = found to be significant using binomial logistic regression)***						
GENDER	×	×	✓	×	✓	×
AGE	×	✓	×	×	✓	×
SOCIAL GRADE	×	×	×	×	×	×
REGION	×	×	×	×	✓	×
QUALIFICATION	✓	×	×	×	✓	×
INCOME	✓	×	×	×	×	×
ETHNICITY	×	×	×	×	×	×
INTERNET ACCESS FREQUENCY	×	×	×	×	×	×
PAST USE OF INTERNET TO SEARCH FOR HEALTH INFORMATION	×	✓	×	×	✓	✓
PRESENCE OR ABSENCE OF A LONG TERM HEALTH CONDITION	✓	×	✓	×	✓	×
NUMBER OF GPS IN SURGERY/LOCAL HEALTH CENTRE	✓	×	×	×	✓	×

8.4.1 Response rate and demographic characteristics

844 respondents over the age of 15 years from England responded to the questionnaire. The socio-demographics that respondents were asked about included gender, age, social grade, region, qualification, income and ethnicity, and these are reported in Table 8-2, both the weighted data used in the analysis as well as the unweighted data. Additional socio-demographic characteristics not used in the analysis were collected by Ipsos MORI as part of their Capibus; these are given in Appendix F. Four further questions related to internet usage and health were also asked, and the responses to these are also listed in Table 8-2. These 11 demographic variables are the independent variables against which other dependent variables were checked for association during the analysis (further details are in the forthcoming sections).

Table 8-2: 11 demographic characteristics of the 844 respondents to the questionnaire

	UNWEIGHTED DATA		WEIGHTED DATA		DIFFERENCE
DEMOGRAPHIC CHARACTERISTIC	NO. OF RESPONDENTS (unweighted data)	%	NO. OF RESPONDENTS (weighted data)	%	% difference between unweighted & weighted data
GENDER					
MALE	433	51.3%	413	48.9%	-2.4%
FEMALE	411	48.7%	431	51.1%	+2.4%
AGE					
15-24	150	17.8%	132	15.7%	-2.1%
25-34	112	13.3%	142	16.8%	+3.5%
35-44	116	13.7%	134	15.9%	+2.2%
45-54	138	16.4%	144	17.1%	+0.7%
55-59	58	6.9%	51	6.1%	-0.8%
60-64	67	7.9%	63	7.4%	-0.5%
65+	203	24.1%	178	21.0%	-3.0%
SOCIAL GRADE*					
AB	191	22.6%	231	27.4%	+4.8%
C1/C2	435	51.5%	412	48.8%	-2.7%
D	124	14.7%	129	15.3%	+0.6%
E	94	11.1%	72	8.6%	+2.5%
GOVERNMENT OFFICE REGION					
EAST MIDLANDS	56	6.6%	73	8.6%	+2.0%
EASTERN	71	8.4%	94	11.1%	+2.7%
LONDON	137	16.2%	130	15.5%	-0.7%
NORTH EAST	41	4.9%	41	4.9%	0.0%
NORTH WEST	126	14.9%	111	13.2%	-1.7%
SOUTH EAST	111	13.2%	137	16.3%	+3.1%
SOUTH WEST	100	11.8%	86	10.2%	-1.6%
WEST MIDLANDS	101	12.0%	88	10.4%	-1.6%
YORKS AND HUMBR	101	12.0%	84	9.9%	-2.1%
QUALIFICATION					
GCSE/ O-LV/CSE/ NVQ12	215	25.5%	212	25.1%	-0.4%
A-LVL OR EQUIV	168	19.9%	160	18.9%	-1.0%
DEGR/ MAST/ PHD	234	27.7%	264	31.3%	+3.6%
NO FORML QUAL	168	19.9%	150	17.8%	-2.1%
OTHER	59	7.0%	59	7.0%	0.0%
INCOME					
UP TO 11,499	102	12.1%	88	10.4%	-1.7%
11,500 - 17,499	78	9.2%	76	9.0%	-0.2%
17,500 - 24,999	47	5.6%	45	5.4%	-0.2%
25,000 - 29,999	56	6.6%	54	6.4%	-0.2%
30,000 - 39,999	63	7.5%	68	8.0%	+0.5%
40,000 - 49,999	49	5.8%	54	6.4%	+0.6%
50,000 - 74,999	66	7.8%	86	10.2%	+2.4%
MORE THAN 75,000	35	4.1%	44	5.3%	+1.2%

	UNWEIGHTED DATA		WEIGHTED DATA		DIFFERENCE
DEMOGRAPHIC CHARACTERISTIC	NO. OF RESPONDENTS (unweighted data)	%	NO. OF RESPONDENTS (weighted data)	%	% difference between unweighted & weighted data
DON'T KNOW	158	18.7%	153	18.2%	-0.5%
REFUSED	190	22.5%	176	20.8%	-1.7%
ETHNICITY					
WHITE	710	84.1%	723	85.9%	+1.8%
NON-WHITE	134	15.9%	118	14.1%	-1.8%
INTERNET ACCESS FREQUENCY					
DAILY	657	77.8%	679	80.4%	+2.6%
WEEKLY	67	7.9%	62	7.3%	-0.6%
MONTHLY	14	1.7%	12	1.5%	-0.2%
NEVER	106	12.6%	91	10.8%	-1.8%
HAVE YOU EVER USED THE INTERNET TO SEARCH FOR HEALTH INFORMATION?					
YES	434	51.4%	458	54.2%	+2.8%
NO	410	48.6%	386	45.8%	-2.8%
DO YOU HAVE A LONGTERM HEALTH CONDITION?					
YES	241	28.6%	222	26.3%	-2.3%
NO	603	71.4%	622	73.7%	+2.3%
APPROXIMATELY HOW MANY GPS ARE THERE IN YOUR CURRENT GP SURGERY?					
1 GP	31	3.7%	29	3.5%	-0.2%
2-3 GPs	203	24.1%	197	23.3%	-0.8%
4-5 GPs	265	31.4%	268	31.8%	+0.4%
6-9 GPs	206	24.4%	210	24.9%	+0.5%
MORE THAN 10 GPS	45	5.3%	45	5.3%	0.0%
DON'T KNOW	94	11.1%	95	11.2%	+0.1%

**The social grades are defined as follows: A: Higher managerial, administrative and professional. B: Intermediate managerial, administrative and professional. C1: Supervisory, clerical and junior managerial, administrative and professional. C2: Skilled manual workers. D: Semi-skilled and unskilled manual workers. E: State pensioners, casual and lowest grade workers, unemployed with state benefits only*

8.4.2 Awareness - public awareness of the opportunity to give feedback in general and on doctor rating websites

As shown in Figure 8-1, this section reports on public awareness of the opportunity to leave feedback about GPs using any method, followed by public awareness of the opportunity to use doctor rating websites to leave feedback about GPs. It also reports on how participants became aware of giving feedback, and the predictors for awareness.

Awareness of the opportunity to give feedback about care from GPs in general (using any method) - 39% (n=326) of respondents were aware that they could give feedback about their experience of receiving care from a GP, whereas 61% (n=518) were not aware that they could give feedback at all.

The effect of 11 demographic variables (in Table 8-2) on awareness was explored using chi-square tests in SPSS. Qualification, income, use of internet to search for health information in the past, presence of a long term condition, and number of GPs in their surgery were found using chi-square tests to be significantly related ($p<0.05$) to the awareness of the option to give feedback about GPs. The combined effect of these five variables was investigated using binomial logistic regression. When the five significant variables were analysed together, the use of internet to search for health information became non-significant, and so it was removed from the final model. However, the other four remained significant, hence the model was adjusted (see Table 8-3):

- **Income** was found to be statistically significant ($p=0.003$), and those with an income of £50,000-£74,999 had the highest odds and were 2.2 times more likely to be aware of the option to give feedback about their experience of care from a GP, in comparison to those whose income was below £11,499.
- **Qualification** was found to be statistically significant ($p=0.002$), and those with a graduate qualification had the highest odds, and were also 2.2 times more likely to be aware than those with no formal qualifications.
- **The presence or absence of a long term condition** was found to be statistically significant ($p=0.004$), and those who did have a long term condition were 1.6 times more likely to be aware of the option to give feedback about a GP than those who did not have a long term condition. This is not surprising considering that those with long term conditions generally use GP services more frequently.
- **The number of GPs in respondents' surgery** was also found to be statistically significant ($p=0.019$), with those who were not aware of the number of GPs present in their surgery being the least likely (64.4% less likely) to be aware of the option to give feedback about GPs, as compared with those who were aware that they had one GP in their surgery. This may suggest that those with limited knowledge about GPs and their services, or even

limited usage of GP services, are naturally less likely to know about the option to give feedback about GPs.

Table 8-3: Adjusted odds ratio* for the effect of set demographic variables on the awareness of the option to give feedback about a GP (95% CI, n=844)

Variable	Odds ratio	95% CI	
Income			***p=0.003***
< £11,499	Ref (1.000)	-	
£11,500 - £17,499	1.790	0.937 – 3.420	
£17,500 - £24,999	1.303	0.608 – 2.792	
£25,000 - £29,999	1.126	0.547 – 2.317	
£30,000 - £39,999	1.307	0.660 – 2.591	
£40,000 - £49,999	0.892	0.425 – 1.872	
£50,000 – £74,999**	2.211	1.131 – 4.320	
More than £75,000	0.534	0.234 – 1.219	
Don't know	0.789	0.436 – 1.429	
Refused	0.826	0.472 – 1.445	
Qualification			***p=0.002***
No formal qualification	Ref (1.000)	-	
GCSE/O-level/CSE/NVQ	1.020	0.628 – 1.659	
A-level or equivalent	1.386	0.832 – 2.309	
Degree/masters/PhD or equivalent**	2.197	1.350 – 3.575	
Other	1.463	0.761 – 2.811	
Long term condition			***p=0.004***
No	Ref (1.000)	-	
Yes**	1.631	1.166 - 2.283	
Number of GPs in the surgery			***p=0.019***
1 GP	Ref (1.000)	-	
2-3 GPs	0.902	0.389 – 2.090	
4-5 GPs	0.899	0.392 - 2.065	
6-9 GPs	0.867	0.372 – 2.018	
More than 10 GPs	0.479	0.170 – 1.352	
Don't know**	0.356	0.138 – 0.917	

Note: .080 (Cox & Snell), .109 (Nagelkerke). Model $\chi 2 = 69.430$, $p = 0.000$
Ref = reference category (odds ratio of 1.000)
** Each odds ratio is adjusted for all the other variables in the table. ** $p < 0.05$*

Awareness of doctor rating websites for giving feedback about experience of receiving care from GPs – All respondents were provided an explanation of doctor rating websites on screen and verbally by the interviewer (see section D of the questionnaire in Appendix 6). They were then asked if they had been aware of doctor rating websites before this survey. 15% (n=128) of respondents said that they had been aware of doctor rating websites previously, and 85% (n=716) said they had not.

The effect of 11 demographic variables (in Table 8-2) as well as two other relevant variables (i. being aware of the option to give feedback in general about GPs, and ii. having given feedback about GPs in the past) were explored on the awareness of doctor rating websites using chi-square tests. The effects on the awareness of doctor rating websites of age, qualifications, income, social grade, as well as frequency of internet usage, having searched the internet for health information, and being aware

of the option to give feedback in general about GPs, and having given feedback about GPs in the past, were all found to be significant using chi-square tests ($p<0.05$). Therefore, the combined effect of these 8 variables was investigated using binomial logistic regression.

When the 8 significant variables were analysed together, qualifications, social grade, income, frequency of internet usage and having given feedback about GPs in the past were found to be statistically non-significant ($p>0.05$), therefore they were removed from the model. After the model was adjusted (see Table 8-4):

- **Age** was found to be significant ($p=0.021$), with those between the ages of 60-64 being 63% less likely to be aware of doctor rating websites than those aged 35-44. This is not surprising considering that people over the age of 60 have lower levels of internet usage in comparison to other age groups.
- Those who had **searched for health information on the internet in the past** were 2.7 times more likely to be aware of doctor rating websites than those who had not.
- Also, those who were **aware of the option to give feedback about a GP using any method**, were 5.6 times more likely to be aware of the existence of doctor rating websites than those who were not aware, suggesting that being aware of any method of giving feedback is a predictor for awareness of doctor rating websites.

Qualifications and income were predictors for the awareness of the option to leave feedback using any method, but were not found to be predictors for the awareness of doctor rating websites. This may suggest that unlike other feedback methods, doctor rating websites may be able to cross the 'socio-economic divide', but not the 'age divide'.

Table 8-4: Adjusted odds ratio* for the effect of a set of demographics and 2 other variables on whether someone was aware of doctor rating websites (95% CI, n=844)

Variable	Odds ratio	95% CI	
Age			***p = 0.021***
15 - 24	0.425	0.181 – 1.000	
25 - 34	1.442	0.753 – 2.762	
35 – 44	Ref (1.000)	-	
45 - 54	0.974	0.493 – 1.927	
55 – 59	1.473	0.627 – 3.461	
60 – 64**	0.366	0.127 – 1.057	
65+	0.779	0.399 – 1.523	
Past use of internet to search for health info.			***p=0.000***
No	Ref (1.000)	-	
Yes**	2.690	1.709 – 4.234	
Awareness of the option to give feedback about GPs			***p = 0.000***
No	Ref (1.000)	-	
Yes**	5.632	3.631 – 8.737	

Note: .129 (Cox & Snell), .226 (Nagelkerke). Model $\chi 2 = 116.910$, $p = 0.000$
Ref = reference category (odds ratio of 1.000)
** Each odds ratio is adjusted for all the other variables in the table.* *** $p < 0.05$*

Which, if any, of the following doctor rating websites are you aware of? From the 15% (n=128) of respondents who were aware of doctor rating websites, 38% (n=54) said they were not aware of a specific website (see Figure 8-2). 43% (n=61) were aware of NHS Choices feedback site, 14% (n=20) were aware of Patient Opinion, 3% (n=5) were aware of PrivateHealth, 1% (n=1) were aware of iwantgreatcare and 2% (n=2) mentioned 'other'. This means that from all the respondents (n=844), only 7% (n=61) were aware of the NHS Choices feedback site, and 2% (n=20) were aware of Patient Opinion. This indicates that awareness of specific doctor rating websites is very low, which is surprising given that the NHS Choices feedback site is an official NHS channel for collecting and presenting patient feedback.

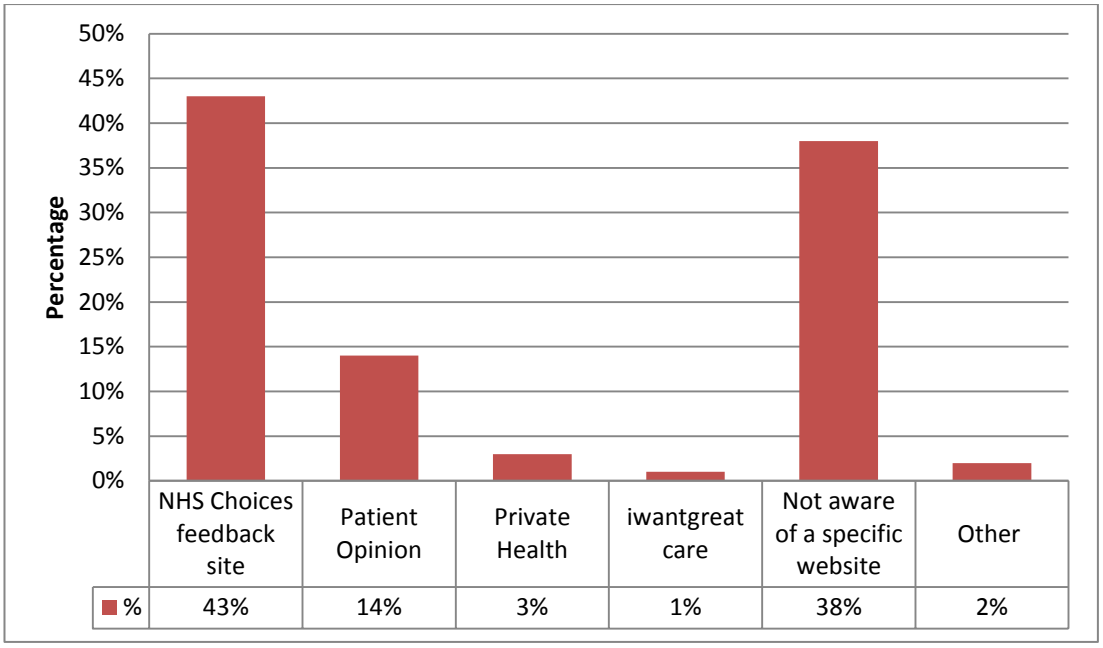


Figure 8-2: Bar graph showing which doctor rating websites respondents (n=128) were aware of

Sources of respondents' awareness – Respondents who were aware of the option to give feedback in general (using any method) about their experience of receiving care from GPs (n=326) and those who were aware of doctor rating websites (n=128) were asked separately in different parts of the questionnaire how they became aware of each method. The responses are recorded in Table 8-5. 26% of respondents were informed by their GP of the option to give feedback (using any method), whereas only 8% of those aware of doctor rating websites were informed by a GP. The results in Table 8-5 suggest that patients' main source of awareness for giving feedback in general (using any method of feedback) is the GP or the NHS, whereas patients' main source of awareness for doctor rating websites is a personal acquaintance or the internet.

Table 8-5: Source of respondents' awareness of giving feedback about their experience of receiving care from a GP in general using any method (n=326) and using doctor rating websites (n=128)

Source of awareness	Any method of feedback	Doctor rating website
GP	26% (n=84)	8% (n=11)
Another healthcare professional	7% (n=23)	7% (n=10)
Receptionist at a GP surgery	16% (n=52)	6% (n=7)
Letter/leaflet/pamphlet/poster about it from the NHS	25% (n=82)	13% (n=17)
NHS website	6% (n=20)	20% (n=25)
Elsewhere on the internet	5% (n=16)	19% (n=25)
Advert	5% (n=16)	12% (n=16)
TV programme	4% (n=14)	6% (n=7)
Friend, family member or colleague	9% (n=31)	21% (n=27)
Work	4% (n=14)	2% (n=3)
Other	11% (n=36)	7% (n=9)

8.4.3 Past use - public experience of giving feedback in general and on doctor rating websites

As shown in Figure 8-1, this section starts by reporting respondents' experiences of giving feedback to GPs using any method, as well as their motivations for leaving or not leaving feedback in the past using any method. It then outlines respondents' past experience of using doctor rating websites for any purpose, and ends with reporting respondents' past experience of using doctor rating websites specifically to give feedback about GPs, as well as their motivations for doing so.

Past experience of giving feedback about GPs in general (using any method) - 19% (n=161) of respondents said that they had formally given feedback about the care they had received from a GP in the past, and 81% (n=683) said they had not. Of those who had given feedback formally in the past, 58% (n=94) had given it directly to the GP, and 35% (n=57) had given it to the GP practice. The remaining 7% (n=10) had given it to an external organisation. This is an interesting finding, and suggests that currently the majority of patients are leaving feedback directly with the GP or the practice.

The effect of 11 demographic variables (in Table 8-2) on whether someone had given feedback in the past about their experience of receiving care from a GP were explored using chi-square tests in SPSS. Gender, age, qualification, use of internet to search for health information in the past, presence of a long term condition, and number of GPs in their surgery were found using chi-square tests to be significantly related ($p<0.05$)

to whether someone had given feedback about their experience in the past. Therefore, the combined effect of these six variables was investigated using a binomial logistic regression.

When the six variables were analysed together, all the variables except gender and long term health condition become statistically non-significant (p>0.05), so they were removed from the model. After the model was adjusted (see Table 8-6):

- **gender** was found to be statistically significant (p=0.002), with female respondents almost twice as likely to have given feedback in the past than male respondents;
- **the presence or absence of a long term health condition** was found to be significant (p=0.002), with those with a long term health condition 1.8 times more likely to have given feedback about their experience of receiving care from a GP in the past. This was not surprising because those with long term health conditions generally access GP services more frequently.

Table 8-6: Adjusted odds ratio* for the effect of a set of demographics on whether someone had given feedback about their experience of receiving care from a GP in the past (95% CI, n=844)

Variable	Odds ratio	95% CI
Gender		***p=0.002***
Female	Ref (1.000)	-
Male	0.574	0.403 - 0.819
Long term health condition		***p=0.002***
No	Ref (1.000)	-
Yes	1.782	1.233 – 2.576

Note: .023 (Cox & Snell), .037 (Nagelkerke). Model $\chi 2 = 19.829$, p =0.000
*Ref = reference category (odds ratio of 1.000) * Each odds ratio is adjusted for all the other variables in the table.*

Motivations for leaving or not leaving feedback using any method – 81% (n=683) of respondents who had never given feedback about a GP were asked using an open ended question why they had not given feedback about a GP in the past. The themes that emerged from the data are in Table 8-7. The most popular was that there was no need for them to leave feedback or they were satisfied with their care (31% and 13% respectively), they were not aware or had not thought of leaving feedback (14% and 4% respectively), and they had never been asked to leave feedback for a GP (7%).

Table 8-7: Major themes that emerged from responses (n=683) to the question: Why haven't you given feedback about your experience of receiving care from a GP? (Ref TY04/A5)

#	Theme	Mentioned by no. of respondents (n)	%	Example (verbatim quote)
1	**No need to leave feedback**	209	31%	"I had no need to leave feedback" (P2347)
2	**Was not aware you could leave feedback**	98	14%	"I didn't know I could. I didn't know how to when you were a bit unhappy" (P1959)
3	**Satisfied with care received**	89	13%	"I've always been satisfied with the service I've received" (P3377)
4	**Never been asked to leave feedback**	51	7%	"Because nobody has ever asked [for feedback]" (P3247)
5	**Do not see GPs frequently**	49	7%	"Very rarely go to doctors" (P2877)
6	**Never thought about it**	26	4%	"Never occurred to me" (P3156)
7	**Not interested in leaving feedback**	26	4%	"I can't be bothered" (P1890)
8	**Feedback was given face-to-face**	7	1%	"Because I tell things to my GPs face-to-face" (P1268)
9	**Leaving feedback will not make a difference**	7	1%	"Does not feel it would amount to anything, and could be a waste of time" (P2187)
10	**Dislike complaining**	5	1%	"I don't like complaining" (P1035)
-	***Other***	*27*	*4%*	-
-	***Don't know***	*147*	*22%*	-

Three of the themes mentioned in Table 8-7 (Themes 2,6 and 9) were explored in the very final section of the questionnaire, where all respondents (n=844) were asked to agree or disagree with statements related to possible motivations for leaving feedback about their experience of receiving care from a GP (see Figure 8-3).

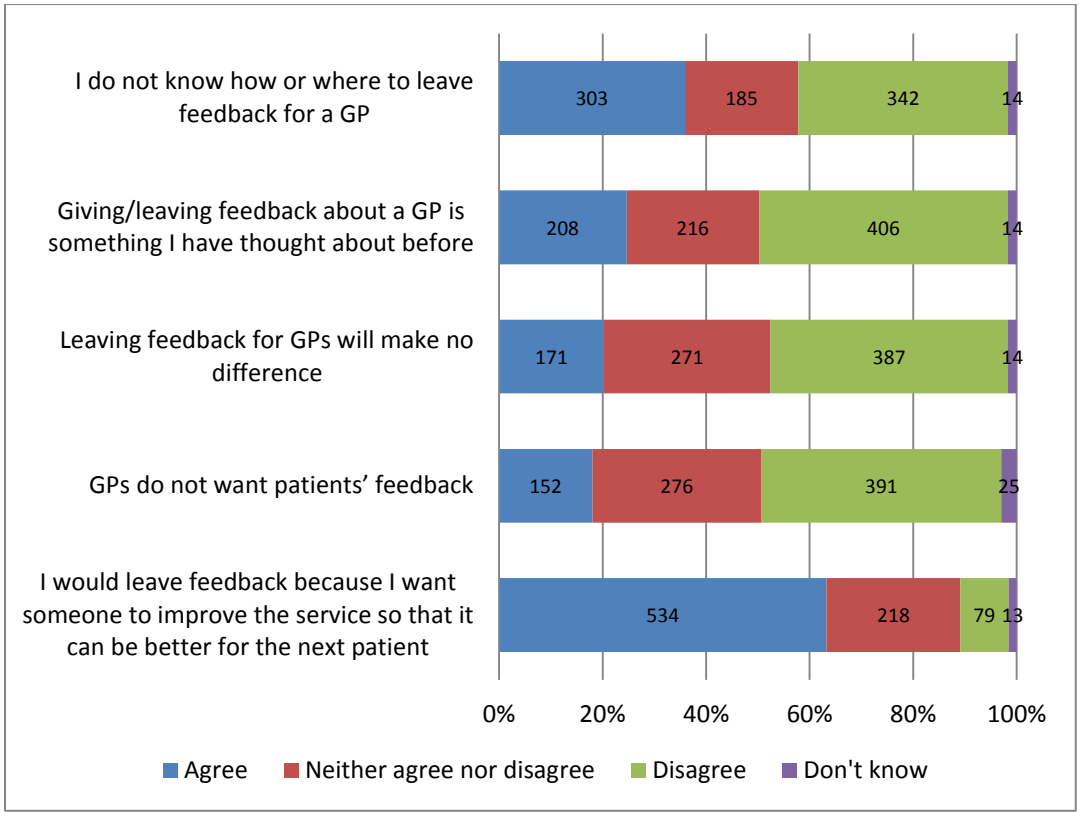


Figure 8-3: Bar chart displaying respondents' (n=844) responses to some of the attitudinal statements asked in the final section of the questionnaire

The results in Figure 8-3 show that 40% of all respondents said they knew how or where to leave feedback, and this is in-line with earlier findings in section 8.4.2, where 39% of respondents were aware of the option to leave feedback about their experience of receiving care from GPs. A similar proportion of respondents said they were not aware of how or where to leave feedback. This lack of awareness appears to be one of the major reasons why most patients are not leaving feedback about their GPs.

However, 48% of respondents had also not thought about giving feedback before (as shown in Figure 8-3), which appears to suggest that maybe patients are apathetic to feedback or have had a good or satisfactory service, so therefore have never really thought of giving feedback. Despite this, only 20% agreed that leaving feedback for GPs would make no difference and only 18% agreed that GPs do not want patients' feedback, which suggests almost one fifth of patients need to be actively convinced their feedback is needed and will be useful. There were a significant number (around a third of respondents) who 'sat on the fence' (with all of these questions, see Figure 8-3) and said they neither agree nor disagree.

Having said that, 63% of respondents agreed that they would leave feedback because they would want someone to improve the service so that it can be better for the next patient and only 9% of respondents disagreed with that. This seems to suggest that altruism may be the major motivation for patients to leave feedback for GPs; as long as patients are convinced their feedback is needed and will be used. Before that, it seems patients need to be aware of where and how they can leave feedback for a GP.

It must be noted that each of the 15 attitudinal questions that were in the final section of the questionnaire (including the ones shown above in Figure 8-3, and the ones shown in Figure 8-5 and Figure 8-8) had a modal average of one third of respondents who selected neither agree nor disagree (the mean average was 29.5%). It is not clear why such a large number selected neither agree nor disagree. It may suggest that around a third of people do not appear to have strong views about leaving feedback for GPs online. Alternatively, it could suggest that the topic does not interest them, or it could be that they were fatigued when they reached this very final stage of the questionnaire. There were however 4.5% of respondents (38/844) who responded to 'neither agree nor disagree' on all 15 of the attitudinal questions in the final section, and 1.3% (11/844) respondents who responded as 'don't know' on all 15 of those questions.

Past usage of doctor rating websites for any purpose – Respondents who were aware of doctor rating websites (n=127) were asked if they had used a doctor rating website before. 15% (n=19) had in the past, and the remaining 85% (n=108) had not. This means that in total, from all the respondents, only 2.25% (n=15) had actually used a doctor rating website before. Given the amount the NHS and other external organisations have invested in establishing OPF websites, and the popularity of other rating websites like Trip Advisor, the very low level of usage at 2.25% is surprising.

The effect of 11 demographic variables (in Table 8-2) on the usage of doctor rating websites was explored using chi-square tests. The variables ethnic origin ($p=0.043$) and region ($p=0.041$) as well as having searched the internet for health information previously ($p=0.007$) were found using Fisher's exact test to be significant on the usage of doctor rating websites. Therefore, the combined effect of these variables was investigated using binomial logistic regression; however none of the variables were found to be significant ($p>0.05$). It was surprising that having searched for health information in the past – which was found to be a predictor for the awareness of

doctor rating website and future consideration of using doctor rating websites (see section 8.4.4) – was not significant for usage.

Past usage of doctor rating websites for giving feedback about a GP – From the 19 respondents who had used a doctor rating site before, 41% (n=8) had used it to read a review for a doctor or hospital, 25% (n=5) had used it to find a doctor or hospital, 19% (n=4) had used it to review their experience of the NHS, and 16% (n=3) had used it to give feedback about their experience of receiving care from a GP. Therefore, only 0.36% (n=3) of the entire sample of respondents (n=844) had used a doctor rating website in the past to give feedback about their experience of receiving care from a GP. This is extremely low, and suggests that even among those patients that are using doctor rating websites, the vast majority are not using it to leave feedback about GPs.

From the three participants that left feedback on a doctor rating website about a GP, two commented on a positive experience and one commented on a negative experience. The reasons the three respondents gave for leaving feedback online was that they either wanted to let the GP know how much they appreciated the consultation, or they believed sharing their experience would benefit the GP, or they wanted to comment on their treatment in general. No other reasons were cited.

8.4.4 Future use – public consideration of giving feedback in the future (using any method) and on doctor rating websites

This section includes the following results (as shown in Figure 8-1): i) future consideration of giving feedback using any method, as well as the preferred method, ii) future consideration of using doctor rating websites for any purpose, and iii) future consideration of using doctor rating websites specifically to give feedback about GPs. This section also includes the reasons why respondents may or may not consider giving feedback on doctor rating websites.

Consideration of giving feedback in the future using any method – All respondents were asked whether they would consider giving feedback in the future about their experience of receiving care from a GP. 76% (n=638) of respondents said they would consider giving feedback in the future, (25% (n=214) said definitely, and 50% (n=424) said possibly). 24% (n=199) said they would not consider giving

feedback in the future, and 1% (n=7) said they do not know. Participants' reasons for not leaving feedback using any method have been discussed in section 8.4.3.

Responses were first combined to form a bivariate variable of yes and no. The effect of 11 demographic variables (in Table 8-2) on consideration of giving feedback in the future was then explored using chi-square tests in SPSS. All variables were found to be significant ($p<0.05$), and so the combined effect of the 11 variables were investigated using a binomial logistic regression. When the 11 variables were analysed together, income, ethnicity and internet access frequency were found to be statistically non-significant ($p>0.05$), therefore they were removed from the model. When the remaining 8 variables were analysed together, social grade became non-significant ($p>0.05$), and so was removed from the model too. After the model was adjusted, seven variables were found to be statistically significant (see Table 8-8):

1. **Gender** was found to be statistically significant ($p=0.013$), with male respondents 37% less likely to consider giving feedback in the future than females.
2. **Age** was also found to be statistically significant ($p=0.001$), with those aged between 35-44, 55-59, and 60-64 around 2.5 times more likely to consider leaving feedback than those aged 65+.
3. Those who had a **long term health condition** were also twice more likely to consider leaving feedback than those did not have a health condition, as would be expected.
4. Similarly, those who had **used the internet in the past to search for health information** were more than twice as likely to consider leaving feedback in the future than those who had not used the internet in the past to search for health information, and this is not surprising given that they have taken an active interest in their own health in the past.
5. **Number of GPs in the respondents' surgery** was also found to be significant with those who had 2-3 GPs in their surgery found to be 2.5 times more likely to consider leaving feedback than those who had just 1 GP in their surgery. This suggests that patients may be less reluctant to give feedback about their GP (or be critical of GP) if they have access to one GP only.
6. **Qualification** was also found to be statistically significant ($p=0.000$), with those who had a graduate qualification being 4 times more likely to consider

leaving feedback than those with no qualifications, and those with GCSEs or equivalent twice as likely to leave feedback than those with no qualifications. Qualification was also a predictor of awareness, but not of usage.

7. **Region** was also found to be significant (p=0.000), with those living in the North West, South East and Yorkshire and Humber, twice as likely to consider leaving feedback than those living in London, and those living in the North East 4.8 times more likely to consider leaving feedback than those living in London. This is an interesting finding, although it is not clear why there are such regional differences, and future studies could explore this.

Table 8-8: Adjusted odds ratio* for the effect of a set of demographics on whether someone will consider giving feedback in the future about a GP (95% CI, n=844)

Variable	Odds ratio	95% CI
Gender		***p = 0.013***
Female	Ref (1.000)	-
Male**	0.630	0.438 – 0.906
Age		***p = 0.001***
15 - 24	0.866	0.457 - 1.638
25 - 34	1.607	0.833 - 3.102
35 – 44**	2.617	1.328 - 5.156
45 - 54	0.864	0.475 - 1.570
55 – 59**	2.555	0.992 - 6.578
60 – 64**	2.483	1.071 - 5.754
65+	Ref (1.000)	-
Region		***p=0.000***
London	Ref (1.000)	-
East Midlands	0.584	0.284 – 1.200
Eastern**	0.825	0.428 – 1.590
North East**	4.823	1.489 – 15.628
North West**	2.330	1.167 – 4.649
South East**	2.448	1.178 – 5.084
South West	2.298	1.055 – 5.003
West Midlands	0.979	0.512 – 1.870
Yorks and Humber**	2.357	1.093 – 5.082
Qualifications		***p=0.000***
No Formal Qualifications	Ref (1.000)	-
GCSE/O-Level/CSE/NVQ**	2.126	1.238 - 3.650
A-Level Or Equivalent (=Nvq3)	1.714	0.952 - 3.084
Degree/Masters/PhD Or Equiv.**	4.086	2.287 - 7.298
Other**	2.649	1.166 - 6.019
Past use of internet to search for health info.		***p = 0.000***
No	Ref (1.000)	-
Yes**	2.392	1.624 - 3.524
Long term health condition		***p = 0.004***
No	Ref (1.000)	-
Yes**	2.078 (1.000)	1.257 - 3.433
No. of GPs in surgery		***p = 0.002***
1 GP	Ref (1.000)	-
2-3 GPs**	2.511	1.034 - 6.097
4-5 GPs	2.010	0.823 - 4.911
6-9 GPs	2.275	0.894 - 5.794
More than 10 GPs	2.318	0.648 - 8.286
Don't know	0.759	0.292 - 1.975

Note: .193 (Cox & Snell), .287 (Nagelkerke). Model $\chi 2 = 180.609$, p =0.000
Ref = reference category (odds ratio of 1.000)
** Each odds ratio is adjusted for all the other variables in the table.* *** p < 0.05*

Public preference on mode of feedback – All respondents who said they would consider giving feedback in the future about a GP (n=776) were asked which mode they would most prefer using to give feedback about their experience with a GP, for both negative and positive feedback. They were provided with a list of 15 methods, and were first asked to select the top three most preferred ways (or modes) to leave feedback and then their main preference. The complete sets of results are provided in

Appendix F. The results presented in this entire sub-section are based on the analysis of the results from this one question.

In summary (see Figure 8-4), the main preferences of respondents for giving feedback about their experience with a GP was i) giving feedback directly to the GP (51% selected this for positive feedback; and 45% for negative feedback); ii) giving feedback to the GP surgery manager (11% for positive; 16% for negative), iii) filling in a feedback form at the surgery or on the practice's website (15% for positive; 17% for negative), iv) posting feedback on a public website (4% for positive; 5% for negative), and v) giving feedback through an app (4% for positive; 4% for negative).

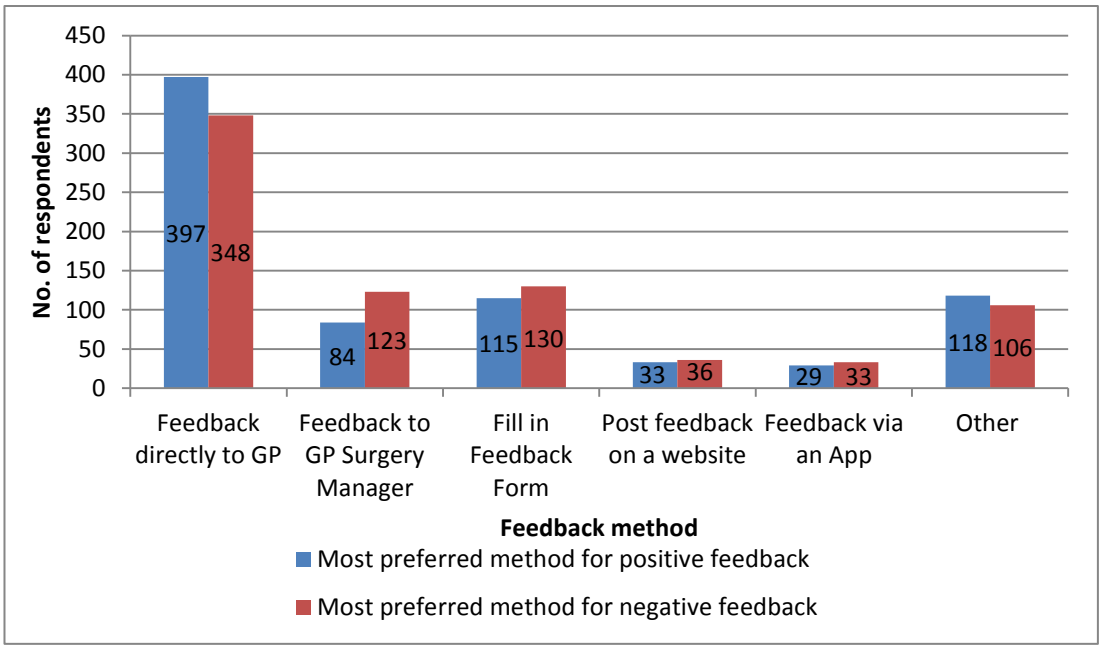


Figure 8-4: Summary of respondents' (n=776) main preference for giving feedback about their experience of receiving care from a GP

It is interesting to note that although results reported in the forthcoming sub-section (page 184) indicate that 18% of all respondents (n=150) would consider using doctor rating websites (both NHS and independent websites) in the future to give feedback about GPs, only 36 respondents selected a doctor rating website as their most preferred method to leave negative feedback about GPs (which corresponds to 5% of all those who would consider giving feedback; and 4% of all 844 respondents). The overwhelming preference for leaving feedback with GPs or the GP surgery correlates with earlier results that indicated that 93% of those who had left feedback for or about a GP in the past, had left it with the GP or GP practice.

Figure 8-4 also demonstrates that patients' most preferred method to give feedback varies depending on whether their feedback is about a negative or a positive experience, suggesting 'patient feedback mode' is partially dependent upon the nature of the experience. This was also found in Study B (see section 6.4.3).

Feedback form (card) vs doctor rating website – From the respondents who would consider leaving feedback in the future (n=776), 9% (n=72) selected a paper-based feedback form at the surgery as their most preferred method for leaving positive feedback and 10% (n=79) selected it for negative feedback. Conversely however, from the same respondents who would consider leaving feedback in the future (n=776), only 4% (n=33) selected posting feedback on a doctor rating website as their most preferred method for leaving positive feedback, and 5% (n=36) for negative feedback.

In the final section of the questionnaire, all respondents (n=844) were asked whether they preferred to leave feedback for a GP online on a doctor rating website rather than on a feedback card at the GP surgery. 24% of respondents agreed that they preferred to leave feedback on a doctor rating website, but 45% disagreed. This as well as the results mentioned above suggests that a feedback form is more preferable for patients on the whole in comparison to a doctor rating website.

Public vs private – Of all the respondents who would consider leaving feedback in the future (n=776), the main preference of 7% (n=51) was filling in a private feedback form on the GP surgery's website for negative feedback, whereas 4% (n=35) selected a public feedback website as their main preference for positive feedback. This suggests that a private form on a GP website is preferred by patients over a public feedback website, either because it is more private and/or goes directly to the GP practice. Similarly, for 3% (n=23) of respondents, their main preference of giving negative feedback was using an app where feedback is sent directly to the GP practice, whereas only 1% (n=9) of respondents' main preference for giving negative feedback was using an app that published the feedback on a NHS feedback website. Again, this suggests a slight preference for the feedback remaining out of the public domain and/or going directly to the GP practice.

Filling in a feedback form by hand vs the GP website – 10% (n=79) of all respondents who would consider leaving feedback (n=776) selected filling in a feedback form by hand at the GP surgery as their main preference for leaving negative

feedback, whereas 7% (n=51) selected filling a feedback form on the GP surgery website as their main preference for negative feedback (both of which would directly reach the GP surgery). Although it shows a slight preference for the feedback form by hand, it does appear to suggest that there is some appetite for a private form on a GP website too, and it is certainly higher than the preference for a public doctor rating website, which was at 5% for negative feedback (as discussed earlier). This also hints towards the unique advantage of being able to give feedback remotely when using a website.

Independent vs the NHS – In relation to leaving feedback with an independent organisation, of all the respondents who consider leaving feedback in the future (n=776), only 1% (n=10) selected an independent website as their most preferred method for both negative and positive feedback, whereas 3% (n=24) selected a NHS website as their most preferred method for both negative and positive. Furthermore, from the same set of respondents (n=776), only 1% (n=5) selected PALs as their most preferred method for positive and negative feedback, and 2 people selected contacting the CQC as their most preferred method. This, as well as previous results that indicated that only 7% of those who had left feedback in the past had done so to other than the GP/practice, altogether suggest that patients have little appetite for giving feedback about GPs to independent/third party organisations. This questions the value of having external organisations for patients to leave feedback about GPs.

Email vs face-to-face vs letter – The respondents who most preferred to give feedback directly to the GP or to the practice manager (from the respondents who would consider leaving feedback in the future), Table 8-9 shows the breakdown for their main preference of the precise method they would most prefer to use. Giving it in person or over the telephone was found to be the most popular way. However, using email was more popular amongst respondents than letter for positive and negative feedback, both to GPs and practice managers. This suggests that as indicated earlier, giving feedback directly to the GP is most preferred by patients, but if patients had to choose between writing a letter or email, email would be the most preferred, and practices and GPs should consider providing this as a medium to leave feedback.

Table 8-9: Those respondents who selected giving feedback directly to the GP or to the practice manager, a breakdown of which methods they most prefer to use to give feedback directly.

	In person/telephone	Letter	Email
GP			
Positive feedback	60% *(n=240)*	16% *(n=63)*	24% *(n=94)*
Negative feedback	53% *(n=184)*	22% *(n=77)*	25% *(n=87)*
Practice manager			
Positive feedback	43% (n=36)	20% (n=17)	37% (n=31)
Negative feedback	42% (n=52)	29% (n=35)	29% (n=35)

Emailing GP vs doctor rating website – Of all those who would consider leaving feedback about GPs (n=776), 12% (n=94) selected email as their most preferred method to leave negative feedback, whereas 5% (n=36) selected doctor rating websites as their most preferred method. Again, this appears to suggest that even among technological methods, a private and direct method appears to be more preferable to a public and indirect method.

Emailing GPs vs feedback form – Among those who considered leaving feedback about GPs (n=776), 12% (n=94) selected email as their most preferred method for negative feedback, whereas 10% (n=79) selected a paper-based feedback form, and 7% (n=51) selected a feedback form on the GP surgery website. This suggests that email is preferred by patients as a mode to give feedback about GPs rather than a paper-based or electronic feedback form.

Giving feedback about GPs on social media – Only 1% (n=6) of respondents who would consider leaving feedback in the future (n=776), selected social media as their most preferred method for positive feedback, and 1% (n=5) as their most preferred method for negative feedback. In the final section of the questionnaire, all respondents (n=844) were asked whether they agree with the following statement: I would consider leaving feedback about a GP on social media (such as Facebook or Twitter). 70% (n=588) of respondents disagreed, 11% (n=92) agreed, 18% (n=150) said they neither agree nor disagree, and 2% (n=15) said they do not know. This together suggests that social media is not a mode of feedback that currently needs to be pursued by GPs, practices or the NHS.

Description of those that selected NHS Choices website as their main preference for leaving negative feedback – 26/776 participants (3%) selected NHS Choices as their main preference for giving negative feedback about GPs. Using this sample alone, a chi-square test showed a significant association (p=0.030) with

gender, with a bias towards male participants (18/26) preferring the NHS Choices website. However, no association was found between this NHS Choices selection and the past usage of internet for health information or the existence of a long term health condition. Chi-square tests or Fishers exact test could not be conducted with other demographics due to the small size of the sample.

Age did appear to be somewhat significant with 20 out of the 26 participants who selected the NHS Choices website being under the age of 44, and the modal age group was 25-34, with 10 participants in that age group. This type of bias towards the younger age group could not be found for those who selected a feedback form at the surgery as their main preference. However, it must be noted that these predictors were not found in the future intention to use doctor rating websites (see page 185), which were conducted with a much larger sample, and suggest that the results in this paragraph should be used with caution.

Reasons for preference of one method over another – Respondents who would consider leaving feedback in the future and had selected their most preferred method to leave feedback were asked in two separate open ended questions their reasons for selecting their most preferred method to leave positive and negative feedback. In total, for positive feedback, 674 individual reasons were mentioned, and for negative feedback, 685 individual reasons were mentioned.

Responses were recorded verbatim and analysed using content analysis. Forty seven codes emerged from the data, which then merged into ten themes. These are illustrated in detail in a table in Appendix F, with corresponding percentages given for each sub-code, separately for both positive and negative feedback. The 10 themes are summarised below in Table 8-10, and illustrate that ease and convenience was the most popular reason for respondents choosing one feedback method over another, followed by the method being a direct way of giving feedback to a GP. These factors may be useful to evaluate the effectiveness of any new feedback method introduced in the NHS.

Table 8-10: Themes illustrating the reasons for respondents' preference for one method of giving feedback about GPs over others

#	Theme	No. of times mentioned as reason for most preferred method for positive feedback (n)	No. of times mentioned as reason for most preferred method for negative feedback (n)	Combined mean average (n)	Example (verbatim quote)
1	**Ease and convenience**	198	201	200	"Ease of providing the feedback" (P1505)
2	**A direct method**	104	91	98	"I prefer direct contact with my GP" (P1744)
3	**Ensures feedback reaches the right person**	24	45	35	"I know they have got the message" (P1793)
4	**A less direct method**	8	46	27	"because [it] is not direct" (P1086)
5	**Leads to GPs' improvement**	21	21	21	"To improve their service to patients" (P1226)
6	**Can give better quality of feedback**	11	20	16	"I just think I could explain it better"(P1726)
7	**Anonymity**	9	18	14	"would want it to be anonymous" (P1821)
8	**Official/formal channel**	5	17	11	"it is an official channel and linked to the surgery direct" (P3156)
9	**GP/Practice can respond**	2	13	8	"S/he would have the overall picture and time to deal with the response" (P3382)
10	**Helps other patients**	8	6	7	"NHS website is what I looked at so might help others" (P3311)

Consideration of future use of doctor rating websites for all purposes (TY17) – All respondents (n=844) were asked if they would consider using doctor rating websites in the future. 42% (n=354) said that they would (8% (n=67) definitely; 34% (n=287) possibly) and 58% (n=490) said that they would not consider using doctor rating websites in the future.

All respondents (n=844) were then asked for which purposes they would use doctor rating websites. 49% (n=412) said they would not use a doctor rating website, 20% (n=166) said they would use it to read other ratings and reviews, 18% (n=154) said they would use it to find a doctor or hospital, 19% (n=161) said they would use it to give feedback about their experience of the NHS, and 18% (n=150) said they would use it for giving feedback about GPs in their surgery.

Using the responses from the latter question (i.e. for which purposes respondents would use doctor rating websites), respondents were divided into those who would consider using doctor rating websites for any reason (51%) and those who would not

(49%) into a new variable. This new variable was used to explore the effect of 11 demographic factors (in Table 8-2) on the consideration for future use of doctor rating websites for any purpose, as well as the effect of an additional variable (consideration of giving feedback in the future in general).

Income, region, ethnicity and number of GPs in surgery were found to be statistically non-significant ($p>0.05$). Therefore, the combined effect of the remaining 8 variables was investigated using binomial logistic regression. When the 8 significant variables were analysed together, gender, qualification, social grade and having a long term health condition were found to be statically non-significant ($p>0.05$) on the consideration of future use of doctor rating websites, and therefore they were removed from the model. The remaining 4 variables were then analysed together (see Table 8-11), and four variables were found to be significant:

1. **Age** was found to be significant ($p=0.000$), with those between the ages of 15-24 3.7 times more likely to consider using doctor rating websites than those over the age of 65, and those between the ages of 35-44 and 45-54 around twice as likely to consider using doctor rating websites than those over the age of 65. This is expected given that general internet usage is significantly lower in those over the age of 65.
2. Those who had **searched for health information on the internet in the past** were 2.4 times more likely to consider using a doctor rating website than those who had not, again indicating that patients who take more interest in their healthcare are more likely to leave feedback on doctor rating websites.
3. Those who **used the internet daily** were 2.6 times more likely to consider using a doctor rating website than those who had never used the internet, and those who used it monthly were 6.5 times more likely to consider using a doctor rating website than those who had never used the internet. Therefore, there is a precedent for previous internet usage being an indicator for intention to use doctor rating websites.
4. Those who said previously that they would **consider giving feedback in the future** were 5.1 times more likely to consider using a doctor rating website than those who said they would not consider giving feedback in the future about care from a GP.

Table 8-11: Adjusted odds ratio* for the effect of a set of demographics and 2 other variables on whether someone would consider using a doctor rating website for any purpose (95% CI, n=844).

Variable	Odds ratio	95% CI	
Age			***p = 0.000***
15 – 24**	3.792	2.153 - 6.677	
25 – 34**	2.146	1.261 - 3.651	
35 – 44	1.666	0.982 - 2.826	
45 – 54**	1.903	1.131 - 3.199	
55 – 59	1.682	0.837 - 3.380	
60 – 64	0.980	0.506 - 1.900	
65+	Ref (1.000)	-	
Past use of internet to search for health info.			***p=0.000***
No	Ref (1.000)	-	
Yes**	2.407	1.733 – 3.344	
Consideration of giving feedback in the future (TY05)			***p = 0.000***
No	Ref (1.000)	-	
Yes**	5.117	3.414 – 7.668	
Internet Usage Frequency			***p=0.001***
Daily*	2.565	1.348 - 4.880	
Weekly	1.111	0.479 - 2.575	
Monthly**	6.495	1.629 - 25.902	
Never	Ref (1.000)	-	

Note: .218 (Cox & Snell), .291 (Nagelkerke). Model $\chi 2 = 208.009$, $p = 0.000$
Ref = reference category (odds ratio of 1.000)
** Each odds ratio is adjusted for all the other variables in the table.* *** $p < 0.05$*

Using doctor rating websites for choice – 20% (n=166) of all respondents (n=844) said they would use doctor rating websites (in the future) to read other ratings and reviews, and 18% (n=154) said they would use it to find a doctor or hospital. Although using doctor rating websites for patient choice was not the focus of this questionnaire, in the final section of the questionnaire all respondents (n=844) were asked whether they agree or disagree with the following statement: "I would benefit from reading about other people's experiences of receiving care from a GP." 45% (n=337) agreed with this statement, 26% (n=221) disagreed, 27% (n=231) said they neither agree nor disagree, and 2% (n=14) said they do not know. This appears to suggest that almost half of participants are in favour of reading other patients' reviews and feedback; but it is not clear from this in which format they would prefer to read that, and how useful that would be in comparison to other metrics. This was not explored however, as patient choice is outside the scope of this research.

Consideration of future use of doctor rating websites to give feedback about GPs (TY18) – 18% (n=150) of all respondents (n=844) said they would consider using doctor rating websites to give feedback about their experience of care from a GP based in their surgery.

The effects of the 11 demographic variables (in Table 8-2) on the consideration of future use of doctor rating websites was explored as well as the following additional variables: 1) awareness of doctor rating websites; 2) past use of doctor rating websites; 3) consideration of future use of doctor rating websites for any purpose; 4) consideration of giving feedback in the future about a GP. Chi-square tests found that only internet usage, previous use of internet to search for health information, consideration of future use of doctor rating websites, and consideration of giving feedback in the future about a GP remained significant ($p<0.05$).

The combined effects of the four variables were investigated using binomial logistic regression. When the four significant variables were analysed together, internet usage, consideration of future use of doctor rating websites, and consideration of giving feedback in the future about a GP became non-significant ($p>0.05$), and hence they were removed from the model. After the model was adjusted (see Table 8-12):

- only **past use of internet to search for health information** remained significant ($p=0.007$), with those who had used the internet to search for health information in the past being 1.6 times more likely to consider using doctor rating websites to give feedback about a GP, than those who had not previously used the internet to search for health information. This suggests that existing engagement and interest in health, as well as being an indicator for patient awareness of doctor rating websites (as mentioned earlier), is also an indicator for patient intention to use doctor rating websites in the future to give feedback about GPs.

Table 8-12: Logistic regression (odds ratio) showing the effect of past use of the internet to search for health information on whether someone would consider using a doctor rating website to give feedback about a GP (95% CI, n=844)

Variable	Odds ratio	95% CI
Internet to search for health info.		***p=0.007***
No	Ref (1.000)	
Yes**	1.649	1.144 – 2.376

Note: .009 (Cox & Snell), .014 (Nagelkerke). Model $\chi 2 = 7.387$, $p = 0.007$
Ref = reference category (odds ratio of 1.000) *** p < 0.05*

Motivations for leaving or not leaving feedback on doctor rating websites – Respondents were also asked in an open ended question why they would or would not consider using doctor rating websites to give feedback about GPs. Responses were transcribed verbatim and analysed using content analysis. 12 major themes emerged

for why respondents would not consider using doctor rating websites (see Table 8-13). A detailed table with sub-themes is given in Appendix F.

Table 8-13: Major themes that emerged from responses (n=673) to why respondents would not consider giving feedback about a GP on a doctor rating website (ref TY19/D7)

#	Theme	Mentioned by no. of respondents	Percentage	Example (verbatim quote)
1	**Not interested in leaving feedback**	96	14%	"More important things to think about" (P2141)
2	**Prefer giving feedback direct to GP or using other methods**	87	13%	"I prefer face-to-face or a form." (P2534)
3	**No need to leave feedback**	80	12%	"Trust them [GPs] to be trained to a certain standard. I don't think it's helpful to leave comments." (P2557)
4	**Internet/website not accessible**	66	10%	"I don't use the computer" (P2658)
5	**Online ratings are biased**	24	4%	"I think there could be hidden agendas. What one person's view of doctor wouldn't necessarily be view of next person" (P2664)
6	**Privacy and security concerns**	20	3%	"I would keep it private and personal, not on public even anonymous website" (P1959)
7	**Dislike the website or not appropriate**	12	2%	"Don't feel they are appropriate / because you can get all sorts of un-meaningful feedback (P1888)
8	**Leaving feedback will not make a difference**	11	2%	"Probably would not make any difference" (P2325)
9	**Website open to abuse**	8	1%	"My experience is people who use them usually have an axe to grind. People rarely put positive experiences down!" (P2282)
10	**Do not see GPs frequently**	6	1%	"I so rarely use the doctors" (P3352)
11	**Cannot see another GP**	6	1%	"It's so hard to change GPs" (P2260)
12	**If asked to use, I would**	6	1%	"I would only give feedback if someone asked me to" (P3142)

Four of the themes that emerged (Themes 1, 3, 8 and 10 in Table 8-13) were the same as themes that emerged from responses to why respondents had not left feedback in the past using any method about their experience of care from GPs (see Table 8-7). However, the remaining 8 themes or reasons were exclusively found when respondents talked about the reasons why they would not leave feedback about their experience of GP care on a doctor rating website, and this suggests that patients do need to make additional deliberations when considering leaving feedback online.

13% of respondents said they prefer to give feedback about a GP using another method instead of doctor rating websites, and 10% said that the website or internet was not accessible to them, which correlates with internet access figures in the UK.

Only 4% were concerned that the ratings online may be biased, and 3% were concerned about privacy and security. This is surprising given that both of these factors were a major concern for patients in Study B and GPs in Study A (privacy and security will be explored in further detail in section 8.4.7 of this chapter).

1% (n=6/673) of respondents said that they did not have the option to see another GP; therefore they would not leave negative feedback about their GP online, and this correlates with earlier findings that patients with 2-3 GPs in their surgery were found to be 2.5 times more likely to consider leaving feedback than those who had only 1 GP in their surgery.

Respondents who would consider using doctor rating websites to give feedback (n=171) were also asked in an open ended question why they would consider using doctor rating websites to give feedback about their experience of receiving care from a GP. The major themes that emerged from the data can be found in Table 8-14.

Table 8-14: Major themes that emerged from responses (n=171) to why respondents would consider giving feedback about GPs on a doctor rating website (ref TY20/D9)

#	Theme	Mentioned by no. of respondents	Percentage	Example (verbatim quote)
1	**Share feedback and help others**	44	26%	"Some[one] else could benefit from knowing about my experience" (P3386)
2	**To give feedback**	40	23%	"To provide feedback to the NHS about patients experience with specific doctors or practices" (P1505)
3	**Easier and convenient**	19	11%	"Because the internet is easily accessible and so therefore quick and easy for me." (P1614)
4	**Improve GP performance**	10	*6%*	"To improve service in my GP" (P1810)
5	**It ensures feedback is received**	4	*2%*	"To ensure that they get the feedback" (P2394)
6	**Private and anonymous**	4	*2%*	"It allows me to be anonymous." (P2113)

Two of the themes that emerged (themes 1 and 3) were also explored in the final section of the questionnaire, where respondents were asked to agree or disagree with statements related to possible motivations for leaving feedback about their experience of GP care (see Figure 8-5).

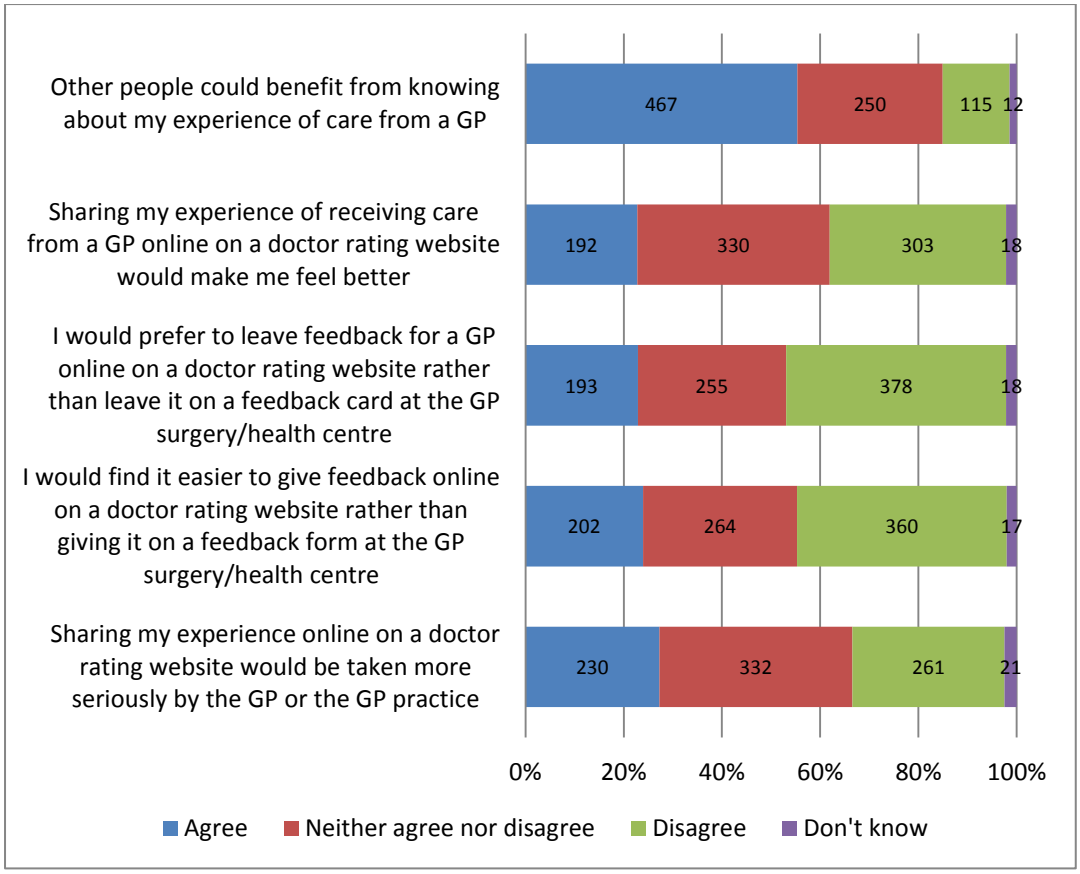


Figure 8-5: Bar chart illustrating participants' (n=844) responses to some of the attitudinal statements related to doctor rating websites asked in the final section of the questionnaire

The most frequently mentioned theme 'share feedback and help others' was mentioned by 44 respondents in response to the open ended question and this was also explored in the final section of the questionnaire with all (n=844) respondents (see Figure 8-5). More than half of respondents (55%) agreed that other people could benefit from knowing about their experience of receiving care from a GP. This suggests altruistic motives for leaving feedback on doctor rating websites. However, 23% of respondents agreed that sharing their experience of receiving care from a GP online on a doctor rating website would make them feel better (even though 36% of respondents disagreed with that). This suggests that some patients believe sharing feedback online has an additional personal benefit.

The theme 'easier and convenient' was mentioned by 19 respondents (see Table 8-14), and this was also explored in the final section of the questionnaire with all (n=844) respondents (see Figure 8-5). 24% of all respondents agreed they would find it easier to give feedback online on a doctor rating website rather than giving comments on a feedback form at the GP surgery. However, 43% of all respondents disagreed and did not believe that, which is surprising given that people tend to associate the internet

with ease of use. Similarly, 23% of all respondents (see Figure 8-5) preferred to leave feedback on a doctor rating website rather than on a feedback form at the GP surgery; whereas 45% of all respondents did not prefer that. This again suggests that patients on the whole prefer feedback forms at the GP surgery rather than doctor rating websites. However, this may not be just because of the physical differences in the mode; it could be because the feedback form is internal to the GP practice, which as shown earlier is preferred by patients.

Another reason for giving feedback online that emerged in Study B but did not emerge in respondents' reasons for considering giving feedback online was explored with all respondents (n=844) in the final section of the questionnaire (see Figure 8-5). 27% of respondents agreed that sharing their experience online on a doctor rating website would be taken more seriously by the GP or the GP practice; however 31% of all respondents disagreed, and did not believe that. Nevertheless, this suggests that almost a third of patients believe that feedback left online will be taken more seriously by the GP or practice, possibly in order to protect their reputation.

Preferred mode to give feedback on doctor rating website and reasons why – Respondents who said that they would consider using doctor rating websites to give feedback about a GP (n=170) were asked which method they would most prefer for giving feedback on a doctor rating website (see Figure 8-6). 35% (n=62) said their personal computer/laptop, 23% (n=40) said a feedback card at the GP surgery (which they can write on and the feedback would then be placed online by the GP surgery), 15% (n=25) said a free app on their smartphone, 12% (n=20) said an iPad or digital device at the GP surgery, 10% (n=17) said a web browser on their smartphone, and 5% (n=6) selected other.

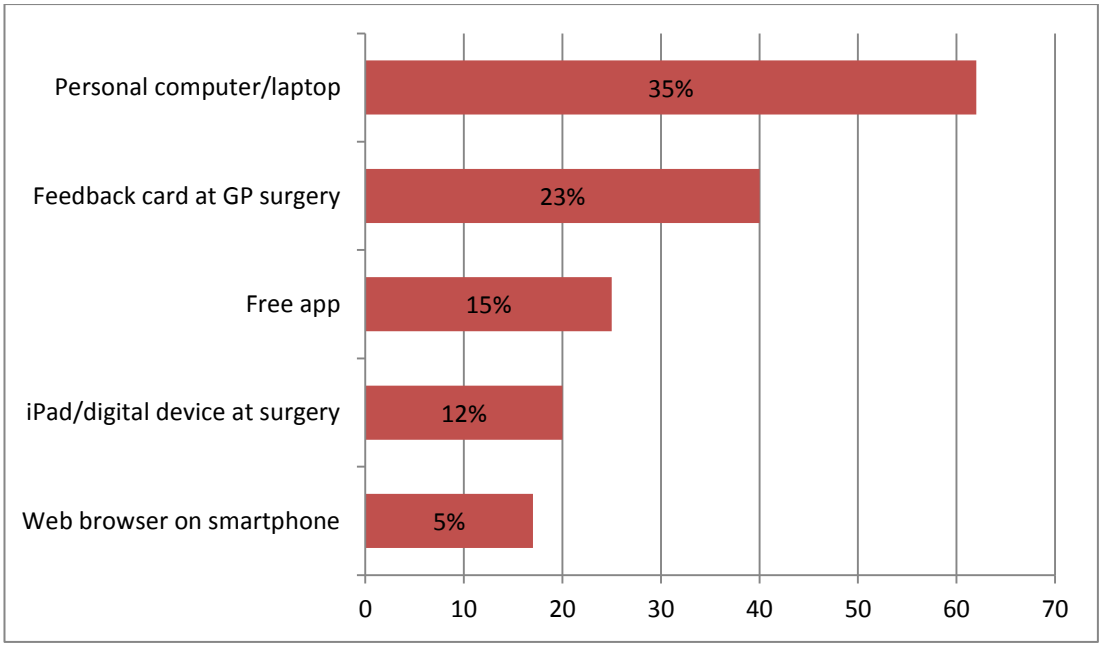


Figure 8-6: Bar chart illustrating respondents' (n=170) most preferred method to leave feedback on doctor rating websites

Although it was not surprising to see that a free app was not very popular (perhaps due to limited app storage on smartphones), it was surprising to see that a feedback card at the GP surgery (a non-digital method) was more preferred than an iPad or another device (a digital method) at the surgery to leave feedback online. This may suggest not only that patients trust the GP surgery to upload the feedback on to the website, but also that non-technological modes of collection can be just as effective, if not more than technological modes, even if in the end all the feedback will end up online.

Respondents (n=170) were then asked why they had chosen their most preferred method to leave feedback on doctor rating websites. 71% (n=112) said it was because the method was easy to use, 68% (n=112) said because it was convenient, 25% (n=41) said because it was quicker (as feedback appears online immediately), 11% (n=18) said you could provide feedback at any time, 9% (n=15) said because you could provide feedback at the time of the issue, 5% (n=8) said because you could provide feedback later, 3% (n=5) said they had concerns about anonymity if they provide feedback on paper, and 1 person said they did not know how to use the internet/apps/iPad. This again suggests that the reason for 23% (n=40/170) of respondents selecting a feedback card to write on rather than any other method was not because they did not know how to use the technological device, rather it was either because it was easier, convenient, in real-time or quick. However, it must be noted that 35% (n=62/170) of

respondents did prefer to leave feedback using their own laptop/computer, again for similar reasons.

8.4.5 Unsolicited feedback vs. solicited feedback

All respondents (n=844) were asked if they are likely or unlikely to give feedback about a GP if they were unsolicited (unprompted) or solicited (prompted) i.e. if a GP or GP surgery asked them to. Results are reported in Figure 8-7. 33% of respondents said they were likely to leave unprompted feedback directly to the GP, whereas 68% of respondents said they were likely to leave feedback if a GP asked them to, and 65% said they were likely to leave feedback if a GP surgery asked them to. This suggests that the GP or GP surgery soliciting patients to leave feedback can double the number of patients leaving feedback about GPs.

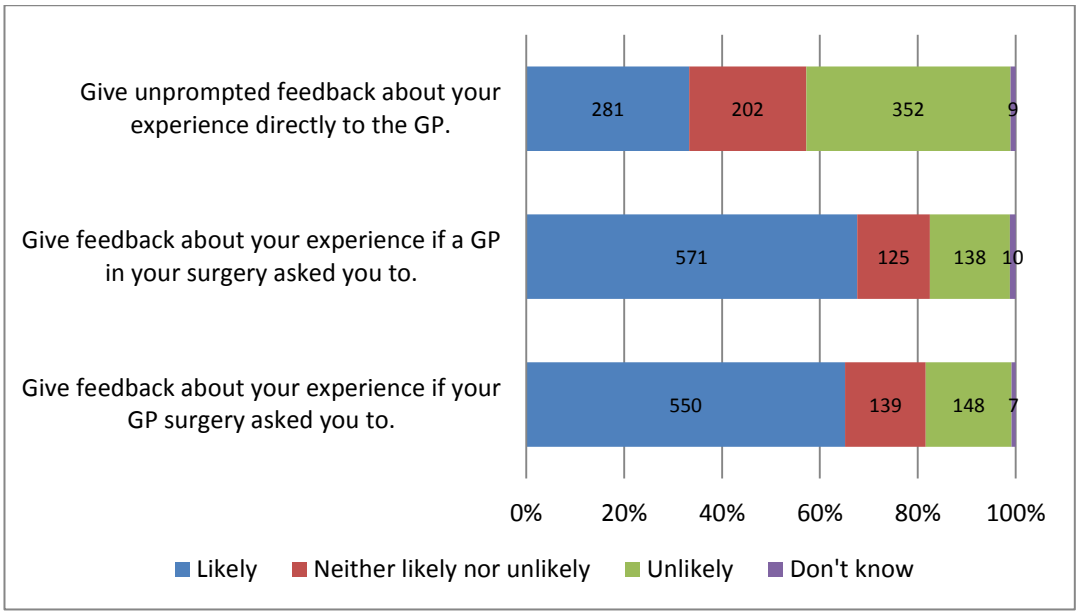


Figure 8-7: Bar chat illustrating results of the question asked to all respondents (n=884): How likely or unlikely are you to do each of the following? (Ref TY07/B5)

8.4.6 Positive feedback vs. negative feedback

All respondents (n=844) were asked whether they would be more likely to give feedback about their GP (using any method) if their experience of care was negative or positive, or whether it would make no difference. 25% (n=235) said they would be more likely to give feedback if their experience of care was negative; 11% (n=89) said they would be more likely to give feedback if their experience was positive; and 45% (n=383) said they are equally likely to give feedback for both positive and negative

experiences. 16% (n=131) said they would not give feedback, and 1% (n=6) said they do not know. This suggests that although some patients may be more likely to leave feedback when their experience is negative rather than positive, almost half will leave it for both positive and negative experiences equally, suggesting unsolicited patient feedback is not always biased towards the negative.

8.4.7 Anonymity and privacy

Disclosing full name on feedback – Respondents who said they would consider giving feedback in the future (n=638) were asked if they would leave their full name on feedback they give directly to the surgery. Similarly, respondents who said they would consider giving feedback on a doctor rating website (n=354) were also asked if they would leave their full name on feedback they give on doctor rating websites. The results are reported in Table 8-15.

A total of 17% (n=109/638) of respondents said they would not consider leaving their full name when they leave feedback directly with the GP practice; whereas 38% (n=136/354) said they would not consider leaving their full name when they leave feedback on a doctor rating website, which is not surprising considering that their name would be in full public view. Furthermore, as expected, respondents were more willing to leave their full name on positive feedback rather than on negative feedback, for feedback left directly with the GP surgery and on doctor rating websites. However, just over half the respondents (51%) suggested they would leave their full name when giving feedback on doctor rating websites, which is rather surprising, given that their name and feedback would be in the public domain. This suggests that around half of patients do not feel the need to maintain their anonymity when leaving feedback online about GPs.

Table 8-15: Participants' responses to whether they would reveal their full name when leaving feedback about a GP directly to the GP surgery (n=638) and on doctor rating websites (n=354).

	Give your full name on feedback you give directly to your GP surgery/ local health centre*	Give your full name on feedback you leave on a doctor rating website*
Yes	**70% (n=446)**	**51% (n=180)**
When giving feedback about positive experiences	*65% (n=414)*	*46% (n=164)*
When giving feedback about negative experiences	*56% (n=360)*	*38% (n=135)*
No (I would not do this)	**17% (n=109)**	**38% (n=136)**
I would not give feedback about a GP using this method	**11% (n=72)**	**9% (n=33)**
Other	**2% (n=11)**	**1% (n=5)**

**The question preceding the statement was as follows: I'm now going to show you a list of things people may choose to do when giving feedback for a GP in their surgery/local health centre. For each one I'd like you to tell me in which situation, if any, you would choose to do each one.*

Furthermore, in the final section of the questionnaire, all respondents (n=844) were asked whether they agree or disagree with the following statement: I am concerned that leaving feedback with my full name on it will impact my relationship with a GP. 32% (n=273) agreed with the statement, 35% (n=293) disagreed, 31% (n=262) neither agreed nor disagreed, and 2% (n=16) said they do not know. It seems that patient opinion is divided over whether there would be ramifications for patients leaving their real name on the feedback they leave about their GP.

Characteristics of those who would consider leaving their full name on negative feedback given on doctor rating websites – As shown in Table 8-15, from those who would consider leaving feedback on doctor rating websites, 38% (n=135/354) of respondents said they would leave their full name on negative feedback. The effects of 11 demographic variables (listed in section 8.4.1) on the consideration of participants leaving full name on negative feedback were then explored using chi-square tests in SPSS. Only age, income, internet usage and the presence or absence of a long term condition was found to be significant ($p<0.05$), therefore, the combined effect of these four variables was investigated using a binomial logistic regression. When the four variables were analysed together, income, internet usage and the presence or absence of a long term condition were found to be statistically non-significant ($p>0.05$), therefore they were removed from the model. After the model was adjusted (see Table 8-16):

- Only **age** remained statistically significant (p=0.000), with only those between the ages of 25-34 less likely (by 35%) to leave their real name on

negative feedback on doctor rating websites than those aged between 15-24. All of the remaining age groups were more likely to leave their full name on negative feedback than those aged 15-24. For example, those between the ages of 60-64 were 4.7 times more likely to leave their full name than those between the ages of 15-24, and those aged over 65 were 2.9 times more likely than 15-24 year olds.

This result is rather unexpected, given than internet familiarity and usage is significantly lower in those over the age of 60. However, it may indicate that those younger are more conscious about leaving their real name online, or more aware of privacy concerns, or it could suggest that those who are younger have less personal confidence in leaving their real name on negative feedback. However, it would be interesting to ascertain whether age is a predictor for leaving one's full name when giving negative feedback directly to the surgery, and this is explored in the next sub-section below.

Table 8-16: Odds ratio for the effect of age on whether someone would consider leaving their full name on negative feedback about their GP on doctor rating websites (95% CI, n=354).

Variable	Odds ratio	95% CI
Age		***p = 0.000***
15 - 24	Ref (1.00)	-
25 - 34	0.643	0.291 - 1.423
35 – 44	1.156	0.524 – 2.551
45 – 54**	2.469	1.139 – 5.352
55 – 59**	2.769	1.028 – 7.457
60 – 64**	4.668	1.612 – 13.523
65+**	2.854	1.268 – 6.422

Note: .086 (Cox & Snell), .116 (Nagelkerke). Model $\chi 2 = 31.628$, $p = 0.000$
Ref = reference category (odds ratio of 1.000) *** p < 0.05*

Characteristics of those who would consider leaving their full name when giving negative feedback directly to the GP surgery – As shown in Table 8-15, from those that would consider giving feedback directly to the GP surgery, 56% (n=360/638) of respondents said they would leave their full name on negative feedback. The effects of 11 demographic variables (listed in section 8.4.1) on consideration of participants leaving their full name on negative feedback they give directly to the surgery were then explored using chi-square tests in SPSS. Age, social grade, income, region, ethnic origin, number of GPs in their surgery, and the presence or absence of a long term condition was found to be significant ($p<0.05$); therefore, the combined effects of these seven variables were investigated using a binomial logistic regression. When the seven variables were analysed together, social grade,

income, number of GPs in their surgery, and the presence or absence of a long term condition were found to be statistically non-significant (p>0.05), therefore they were removed from the model. After the model was adjusted (see Table 8-17):

- **Age** was significant (p=0.013), with only those between the ages of 25-34 less likely (by 18%) to consider leaving their full name on negative feedback they give directly to the GP surgery than those between the ages of 15-24. The rest of the age groups were more likely to leave their full name than those aged 15-24. For example, those over the age of 65 were 2.2 times more likely to leave their full name on negative feedback in comparison to those between the ages of 15-24.
- **Region** was significant (p=0.021), with those living in the South East 2.6 times more likely to leave their full name than those living in London.
- **Ethnicity** was also significant (p=0.007), with those white being 2.2 times more likely to leave their full name on feedback than those that were non-white.

It is interesting to note that for both feedback left directly with the practice and feedback left on doctor rating websites, those that are older in age are more likely to leave their full name on negative feedback. Region and ethnicity were also found to be predictors for leaving one's full name on negative feedback left directly with the GP surgery, but not on doctor rating websites, suggesting perhaps that doctor rating websites may be crossing across the ethnic and regional divide found for leaving feedback with the GP surgery.

Table 8-17: Adjusted odds ratio* for the effect of a set of demographics on whether someone would consider leaving their full name on feedback they leave directly with the GP surgery (95% CI, n=638).

Variable	Odds ratio	95% CI
Age		***p = 0.013***
15 - 24	Ref (1.000)	-
25 - 34	0.826	0.456 – 3.043
35 – 44	1.661	0.907 – 3.043
45 - 54	1.224	0.664 – 2.257
55 – 59**	1.614	0.739 – 3.525
60 – 64**	1.976	0.926 – 4.216
65+	2.230	1.218 – 4.082
Region		***p=0.021***
London	Ref (1.000)	-
East Midlands	1.399	0.631 – 3.105
Eastern	1.013	0.510 – 2.008
North East	0.741	0.323 – 1.699
North West	1.109	0.583 – 2.109
South East**	2.637	1.406 – 4.944
South West	1.799	0.914 – 3.543
West Midlands	1.049	0.512 – 2.149
Yorks and Humber	1.329	0.679 – 2.598
Ethnicity		***p = 0.007***
White**	2.153	1.238 – 3.745
Non-white	Ref (1.000)	-

Note: .096 (Cox & Snell), .128 (Nagelkerke). Model $\chi 2 = 64.078$, $p = 0.000$
Ref = reference category (odds ratio of 1.000)
** Each odds ratio is adjusted for all the other variables in the table.* *** p < 0.05*

Concerns about privacy when leaving feedback – In the final section of the questionnaire, respondents were asked about their concerns over privacy (see Figure 8-8).

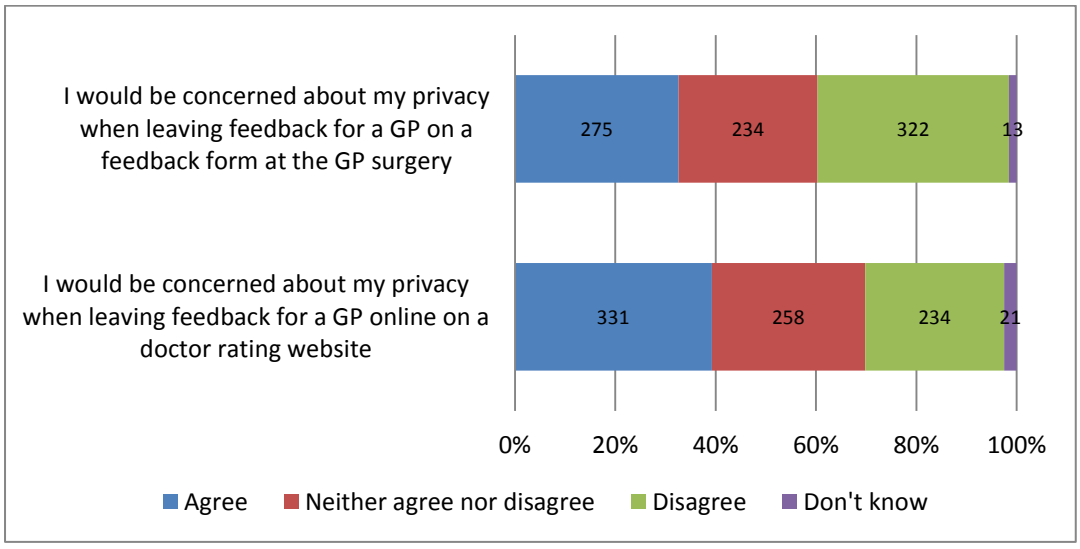


Figure 8-8: Bar chart illustrating participants' (n=844) responses to attitudinal statements about privacy asked in the final section of the questionnaire

The results indicate that 33% of respondents would be concerned about their privacy when leaving feedback on a feedback form at the surgery, whereas 39% of

respondents would be concerned about their privacy on a doctor rating website. The difference is expected due to the public nature of the feedback online, however the difference is not huge, and this is surprising considering that leaving feedback online makes the patient more exposed. Privacy concerns about using OPF websites are expected due to the transparent nature of the feedback; however, what needs addressing in the future is why a third of respondents are concerned about their privacy when leaving feedback on a feedback form at the GP surgery.

Disclosing GP's name on feedback – Respondents who said they would consider giving feedback in the future directly to their GP surgery (n=638), and respondents who said they would consider using a doctor rating website in the future for any purpose (n=354), were both asked whether they would mention a GP by name both on feedback they give to the surgery and on doctor rating websites (see Table 8-18). 74% said they would mention a GP by name on feedback to the GP surgery, and 60% said they would do so on doctor rating websites. The latter is surprising given that results from Study B suggested that more patients preferred to protect their GPs' privacy, and furthermore, the main doctor rating website in England (the NHS Choices feedback website) does not allow GPs' names to be left on feedback posted on their website. As expected however, respondents were more likely to leave a GP's name on positive feedback rather than on negative feedback (see Table 8-18).

Table 8-18: Participants' responses to whether they would mention the GP's name when leaving feedback about a GP directly to the GP surgery (n=638) and on doctor rating websites (n=354)

	Mention a GP by name on feedback you give to your GP surgery/local health centre*	Mention a GP by name on feedback you leave on a doctor rating website*
Yes	**74% (n=469)**	**60% (n=214)**
When giving feedback about positive experiences	*69% (n=443)*	*56% (n=199)*
When giving feedback about negative experiences	*60% (n=381)*	*45% (n=158)*
No (I would not do this)	**16% (n=104)**	**26% (n=93)**
I would not give feedback about a GP using this method	**9% (n=57)**	**12% (n=42)**
Other	**1% (n=8)**	**1% (n=5)**

**The question preceding the statement was as follows: "I'm now going to show you a list of things people may choose to do when giving feedback for a GP in their surgery/local health centre. For each one I'd like you to tell me in which situation, if any, you would choose to do each one."*

8.5 DISCUSSION

Background – In this study, public awareness, usage and attitudes were explored for both doctor rating websites and other feedback methods available in general practice. This was to allow for adequate comparison and a more comprehensive understanding of public awareness and usage of doctor rating websites, rather than an isolated one, as previous researchers in this field have conducted (Burkle and Keegan 2015; Emmert et al. 2013a; Galizzi et al. 2012; Hanauer et al. 2014b; Terlutter et al. 2014). These researchers also explored the effect or association of socio-demographic variables and other health factors on the usage and awareness of doctor rating websites, and used some of the factors to explain the variation in results. This was also conducted in this study; however, this study went a step further and explored the motivations and barriers to usage of doctor rating websites, and how that compared to motivations and barriers towards other methods. This was useful to explore, because the results of this present study suggest that socio-demographics and health status is not sufficient alone to explain the variance in awareness and usage. This study was also unique in that it focused specifically on using doctor rating websites to give feedback about GPs, whereas all of the previous studies (Burkle and Keegan 2015; Emmert et al. 2013a; Galizzi et al. 2012; Hanauer et al. 2014b; Terlutter et al. 2014) explored doctor rating websites more generally (for feedback and for choice), and asked respondents to comment on its overall use for all healthcare services.

Public awareness of doctor rating websites – The results indicate that 15% of the population in England are aware of the existence of doctor rating websites to give feedback to a GP, whereas 39% are aware that they can give feedback using any method. The level of awareness found in this study is in line with findings from a previous study by Galizzi et al. (2012) who found that 15% of their London based respondents were aware of the existence of doctor rating websites, although it was not clear for which purpose they were aware of such websites, and which specific websites they were aware of. However, they suggested that this indicated low awareness amongst the population in England.

The findings from the present study suggest that awareness of doctor rating websites to give feedback about a GP, compared with awareness of the option to give feedback about a GP using any method, is not low. This is because almost half of those who are aware of the option to give feedback about a GP are aware of the existence of doctor

rating websites (for feedback on GPs). Despite this, 38% of those that were aware of doctor rating websites were not aware of a specific website, and only 7% of all respondents were aware of the NHS Choices feedback website, and 2% of Patient Opinion. This indicates that awareness of specific doctor rating websites is low, which is surprising given that the NHS Choices feedback website is an official channel for patients in England to leave feedback about healthcare services (although it is unknown how well, if at all, it is promoted to patients and the public).

Higher levels of awareness of doctor rating websites were found outside of the UK, with the highest found in the USA at 65% by Hanauer et al. (2014b), and in Germany, at 29.3% in 2012 (Terlutter et al. 2014) and 32% in 2013 (Emmert et al. 2013a). The higher levels of awareness in comparison to what was found in this study may be partially explained by the higher usage and popularity of private healthcare in both countries, but there could also be a sampling effect, as the aforementioned studies were all conducted using online panel sampling.

The results from the present study indicate that awareness of doctor rating websites (unlike awareness of giving feedback to a GP in general), is not dependent on being wealthier, having better qualifications, having a long term condition (and possibly using GP services more frequently) and knowing how many GPs practice in your surgery. Rather, age and having searched for health information in the past were found to be the only predictors for awareness of doctor rating websites. Age was also found to be significant by Galizzi et al. (2012), and this they suggest is not surprising because elderly people use the internet less frequently. If a person has searched for health information in the past, this may suggest that: a) they know how to use the internet (and may have access to it too) and b) they are actively interested in their own health. It is therefore not surprising that they are more likely to be aware of doctor rating websites.

However, having a long term condition and knowing how many GPs practice in your surgery may suggest that a person would have more frequent access to GP services, and both of these were found to be predictors for the awareness of giving feedback to GPs in general, but not for doctor rating websites. This may suggest that information about doctor rating websites (unlike other feedback methods) may not be coming from the GP or the practice. This is further supported strongly by the results on sources of awareness which suggest that patients' main source of awareness to give

feedback (using any method) is the GP or the NHS, whereas patients' main source of awareness for doctor rating websites is a personal acquaintance or the internet.

In London, Galizzi et al. (2012) found that as well as age, ethnicity was significant for awareness, with white respondents less likely to be aware of these websites; however this was not found in this study, although white respondents were found to be significantly more likely to leave their full name when leaving negative feedback directly with the GP practice. In Germany, Emmert et al. (2013a) found that differences in age group were not statistically significant, and neither was education, employment, internet use, and health status. However, unlike this study, they found that female respondents were more likely to be aware of doctor rating websites, as well as those widowed, and those with higher healthcare utilization. In this study, female respondents were found to be more likely than male respondents to have given feedback in the past using any method.

Public usage of doctor rating websites – The results indicate that 19% of the population in England have given feedback in the past using any method, whereas only 0.36% of the population have given feedback using doctor rating websites, which is significantly lower. The level of use of doctor rating websites to specifically give feedback or review GPs in England had not been explored in previous studies; however Galizzi et al. (2012) did explore usage of doctor rating websites and found that 3% of their Londoners' sample (n=200) had used doctor rating websites, although again it was not evident for which purpose. This is similar to the finding of this study, that 2.25% of the population had used a doctor rating website before for any of the purposes. The low level of usage indicates that patients are not using doctor rating websites, especially not to give feedback about GPs. This is surprising given that the NHS recently spent £1.25M piloting a new doctor rating website called CareConnect (Shah 2015).

Outside of the UK, usage of doctor rating websites was found to be much higher by academics. A recent study in the USA (in Rochester Minnesota) reported that 16% of the surveyed sample had used a doctor rating website, and 3% had used it to give feedback (Burkle and Keegan 2015). This was different to another study in the USA, conducted in 2012, which reported general usage at 23%, and found that 6% of parents had left ratings for doctors online (Hanauer et al. 2014a). The difference may be partly because the latter study used an online panel as the survey mode, and the

former study used a written questionnaire, or that the former was conducted in a single healthcare setting.

Usage of doctor rating websites was also high in Germany. In 2013, 25% of the population had used a doctor rating website to search for a doctor, and 11% to leave feedback or ratings (Emmert et al. 2013a). Similarly, Terlutter et al. (2014) discovered in Germany (in 2012) that 26% of the population had used a doctor rating website before, although it was not clear for which purpose. In Austria, researchers conducted an experimental study based on a convenient sample and found that 47% of respondents had used a doctor rating website, and 6% had used it to leave feedback (Grabner-Kräuter and Waiguny 2015). The difference in results may be due to regional differences in the diffusion of doctor rating websites, however, there may also be a sampling effect, because all of the studies outside of the UK with the exception of the one conducted by Burkle and Keegan (2015) used an online panel as their sample population. The use of online sampling may have affected results, because those who are online, and had used the internet to search for health information, may be more likely to be aware of and use doctor rating websites than those that had not, as results from this present study suggest.

In the USA and Germany, academics found various predictors for usage of doctor rating websites, such as the presence of a long term condition, advanced education, age and gender (see section 3.3.5). Predictors for the usage of doctor rating websites for feedback about GPs could not be computed in this study because only 0.36% of respondents had used a doctor rating website for that purpose. Yet results do indicate that female respondents and those with long term health conditions are significantly more likely to have given feedback in the past to a GP (using any method). Those with long term health conditions tend to use GP services more than those who do not have a long term health condition, and so it is not surprising that they are more likely to leave feedback.

Future use of doctor rating websites – The results indicate that although 76% of the population in England would consider giving feedback in the future to a GP using any method, only 18% would consider giving feedback in the future to a GP on a doctor rating website. This suggests that more than half of respondents would consider giving feedback to a GP but not on a doctor rating website. Similarly, 33% of the population would consider using doctor rating websites but not to leave feedback

for a GP. This, as well as the 0.36% past usage of doctor rating websites, and only 4-5% selecting doctor rating websites as their most preferred feedback method, questions whether doctor rating websites are really wanted or needed by the public for leaving feedback about GPs.

The only significant predictor for the future use of doctor rating websites for giving feedback about GPs was the past use of internet to search for health information, with those that had were found to be 1.6 times more likely to consider using doctor rating websites to give feedback about a GP than those that had not. This predictor is not surprising given it indicates an active interest in one's health as well as familiarity with the internet. What was surprising was the absence of six other predictors which were found to be significant for the future consideration of using any method to leave feedback about GPs. These predictors indicated that those that are either female, younger in age, have a long term health condition, have higher qualifications, have more GPs in their surgery, or live outside of London are much more likely to consider leaving feedback about a GP using any method. This could be seen as a positive suggestion that doctor rating websites, unlike other feedback methods, may span across the age, social and regional divide, and appeal to everyone who takes an active interest in their own health and is familiar with the internet to pursue that interest.

For consideration of using doctor rating websites in the future for any purpose (and not just giving feedback about a GP), in addition to past use of internet to search for health information, the respondent's age and internet consumption were also found to be significant predictors. This is in contrast to Galizzi et al.'s (2012) findings with Londoners in which income, ethnicity and the doctor-patient relationship were the significant predictors for future intention to use doctor rating websites for any purpose.

Attitudes, motivation and barriers to using doctor rating websites – There is low usage of doctor rating websites in England, as evident from a previous analysis of the NHS Choices website (Greaves et al. 2012b), and the results of this study, which suggests that only 0.36% of the public in England have used doctor rating websites to give feedback about a GP. Similarly, findings from the present study also suggest that while three quarters of the population (76%) would consider giving feedback about a GP in the future, less than 1 in 5 (only 18%) would consider using doctor rating

websites, which suggests that the mode 'doctor rating website' may not be a suitable method for many.

The results of this study also suggest that socio-demographic factors and health status cannot alone explain the variances in awareness, usage and future consideration to use doctor rating websites. Unlike previous studies on doctor rating websites (such as Burkle and Keegan 2015; Emmert et al. 2013a; Galizzi et al. 2012; Hanauer et al. 2014b; Terlutter et al. 2014), this study explored the reasons why patients may or may not consider using doctor rating websites in the future, and how that compares to leaving feedback in general.

The results suggest that some patients are not using doctor rating websites to leave feedback because they do not want to leave feedback about a GP (citing reasons such as they are not interested, they do not feel there is a need to, and that leaving feedback will make no difference), whereas others prefer using another method instead of doctor rating websites (cited by 13%), or have issues and concerns about doctor rating websites. The concerns cited include: i) they do not find the internet or the website accessible (cited by 10%), ii) they believe online ratings are biased or subject to abuse (cited by 4%), or iii) they have security and privacy concerns about leaving feedback online (cited by 3%). These concerns were also raised by patients in Study B (see Chapter 6), and GPs in Study A (see Chapter 5). Similarly, Hanauer et al. (2014a) reported that 43% of their participants in the USA stated a lack of trust in the information on doctor rating websites.

Conversely however, the results suggest that those in favour of leaving feedback on a doctor rating website are motivated primarily by their ability to share feedback and help other patients. This altruistic motive was found in Study B too. Others cited more personal benefits, such as ease and convenience of using a website, and that it could be more private, and they could remain anonymous, and these reasons were also found in Study B. Others when asked believed that leaving feedback online would make them feel better, and that feedback left online would be taken more seriously by the GP or the practice.

Ease and convenience, as well as anonymity, were perceived as reasons for patients preferring to leave feedback on a private NHS feedback website in a study with Scottish patients (Entwistle et al. 2003). However, unlike the findings from this

study, altruistic motives were not found in Entwistle et al's study. Furthermore, their participants cited other reasons that were not found in this study such as speed, having a copy of the communication, avoiding face-to-face confrontation with staff, and less investment of staff time.

Although privacy and anonymity were raised as a fundamental problem with OPF websites by patients and GPs in studies A and B, the results from this study suggest that they are not as central to the issue as previously found. This is because only 3% (n=20) of respondents mentioned it as a reason for not leaving feedback on doctor rating websites. However, when asked specifically, 39% of respondents were concerned about their privacy when leaving feedback online; but 33% were also concerned about their privacy when leaving feedback on a form at the surgery. This suggests that concerns about privacy are not exclusive to doctor rating websites. In the USA, Hanauer et al. (2014a) reported that 34% of participants were concerned their identity may be revealed, and 26% were concerned that doctors may take action against them. This is in contrast to findings from this study, where more than half of patients who would consider leaving feedback on doctor rating websites would like to leave their real name and their GP's name online too.

Currently in the UK, NHS England does not allow patients to leave GPs' names on their website but does allow the patient to remain anonymous (NHS Choices 2015). This is possible because it is a 'practice-based' feedback websites, whereas websites like iwantgreatcare.org are 'physician-based', and this means feedback has to be associated with a specific named GP. Study A found that GPs were not keen on being named online, though some of them also believed that anonymous feedback was almost impossible to use, because it was not clear who the feedback was for, and what instance or situation the feedback was about. However, the results from this study suggest that 26% of the public would not mention a GP by name when leaving feedback online, and would therefore not consider using websites that are 'physician-based' (such as iwantgreatcare.org). One option could be to have a code for each consultation that is only known to patient and GP or practice. This code could be entered online, and so the feedback is both anonymous and identifiable.

Public preference on mode of feedback and other findings – The results suggest that there is no one most preferred way for patients to leave feedback about a GP, and this was also found in Study B, and by Entwistle et al. (2003) in a study with Scottish

patients. However, like the results of Study B, the present study also found rather surprisingly that almost half of those who would consider leaving feedback for a GP would prefer to give feedback directly to the GP, even when it is negative feedback. Furthermore, the two major reasons for choosing one mode of feedback over another were ease and convenience, followed by the method being a direct way of giving feedback (and Study B revealed that the latter was so that patient feedback reaches the GP and is used by the GP for improvement purposes). These are interesting findings, because currently there is little formal provision in general practice in England to give feedback directly to the GP.

Current formal provisions for leaving feedback about GPs in the NHS also include the NHS Friends and Family Test (FFT) card, which is a paper-based feedback form that is used in most GP practices in England (Gillam and Newbould 2016). The paper-based feedback form was only selected by 10% of respondents (who would consider leaving feedback in the future) as their most preferred method for leaving negative feedback for a GP. Similarly, use of OPF websites to report negative experiences was selected as the main preference by only 5% of respondents. In contrast, 45% of patients' most preferred method to leave negative feedback was directly with the practice, and 16% directly with the practice manager. The vast majority of patients (93%) who had given feedback in the past had given it directly to the GP or practice.

These results as well as others suggest that current methods available in general practice to leave feedback are on the whole not the most preferred methods for patients to leave feedback, and therefore GP practices and the NHS need to consider alternative ways and methods to collect feedback, such as giving patients the option to send feedback through email, which was selected by 12% of respondents (who would consider leaving feedback in the future) as their most preferred method. This also questions the value of OPF websites, and questions whether patients in England really want or need these types of websites to leave feedback about GPs.

Although preference for leaving feedback online was minimal, one of the interesting findings from the results was that more people prefer to leave feedback online on a private feedback form on the GP surgery website, rather than leaving it on a (public) doctor rating website. Similarly, although more people preferred to give feedback directly to the GP in person or telephone, in comparison to writing a letter, more respondents preferred to use email to send feedback. Furthermore, an app was found

to be almost the same in popularity as leaving feedback on a doctor rating website, although again the main preference was to use an app that would give the feedback to the GP surgery directly rather than an app that would publish the feedback online. These findings support the notion that many patients prefer to give feedback directly to the GP and practice rather than leaving feedback in the public domain, and these alternative modes of leaving feedback need to be taken into consideration by GPs and GP practices in England, if they want to engage and increase the volume of patient experience feedback.

Among those who would consider leaving feedback on doctor rating websites, more than half would prefer to give it whilst they are away from their personal computer, for example using a feedback card at the surgery (which the practice could then place online), an app, iPad or kiosk at the surgery, and using a web browser on a mobile phone. Again, this suggests that alternative modes to leave feedback on doctor rating websites need to be considered by OPF providers and GP practices, because patients appear to like the flexibility this may afford them, in terms of ease and ability to be situated at the surgery while leaving feedback or the option to give feedback whilst on the move. This was also found in Study B.

The findings suggest that patients prefer a NHS website to an independent website when leaving feedback for GPs, because it is the official and more formal channel. Furthermore, the vast majority of patients (93%) who had given feedback in the past had given it internal to the practice. This is in contrast to findings from a report by Davidson et al. (2010) who found that patients preferred to leave feedback on an independent website rather than a NHS website, because they considered the independent website to be more trustworthy. This was not found in this study; however, this may be because the focus of this present study was solely about giving feedback to GPs, whereas their research examined feedback for all healthcare services in England.

Using social media to give feedback about GPs was very unpopular in this study, with only 1% selecting it as their main preference, and only 11% agreeing that they would consider giving feedback about GPs on social media. GPs in Study A were also vehemently opposed to patients using social media to give feedback, although they recognised that OPF appeared to be heading that way. NHS England on the other hand added the functionality to allow patients to leave feedback on social media

when they introduced their £1.25M pilot multi-channel feedback website called CareConnect in 2014-15 (McBeth 2015). Tweets sent to them were analysed by the researcher, and there were no messages sent to them giving feedback or complaining about a GP. This, as well as findings from this present study, suggest that currently there is no need for GP practices or the NHS to use social media to collect feedback about GPs.

Advocates of OPF argue that the majority of feedback left online is positive (Alemi et al. 2012; Black et al. 2009; Detz et al. 2013; Emmert and Meier 2013; Emmert et al. 2014; Gao et al. 2012; Greaves et al. 2012b; Kadry et al. 2011; Lagu et al. 2013, 2010; López et al. 2012) but GPs in Study A were concerned and believed that the majority of OPF is negative. This argument has been raised in opinion articles (Boffey 2011; McCartney 2009) and literature too (Gao et al. 2012; Merrell et al. 2013). Results from Study B also suggest that patients were much more likely to leave feedback when their experience was extremely negative.

Although findings from this study suggest that patients are more likely to leave feedback (using any method) when their experience is negative rather than when it is positive, almost half of patients will leave it for both positive and negative experiences equally, suggesting that unsolicited patient feedback is not always biased towards negative feedback. The findings from this study also confirm findings from Study B which suggested that patients' most preferred mode to leave feedback shifts according to the nature of feedback they are giving. This suggests that some patients may be more likely to leave negative feedback online and leave positive feedback elsewhere, indicating a slight negative bias in feedback on doctor rating websites. Findings from this study also indicate that patients are twice more likely to leave feedback if the GP or the GP surgery asks them to. Therefore, if GPs want to see more positive feedback about them on OPF websites, the most effective thing for them to do is to ask their patients to leave feedback on OPF websites.

8.6 CONCLUSIONS

The findings from this study portray an understanding of public views on the use of OPF websites for giving feedback about GPs, within the context of other feedback mechanisms available in general practice. The findings suggest that although awareness is not so poor of doctor rating websites when compared to awareness of

giving feedback in general, past usage is extremely uncommon (at 0.36% for feedback about GPs), and so is future consideration to use doctor rating websites for giving feedback about GPs (82% of the public indicated that they will not consider using doctor rating websites to give feedback in the future; although a further 33% of the population would consider using doctor rating websites but not to leave feedback for a GP). The findings also suggest that awareness, socio-demographic factors and health status does not explain the variance in consideration of future use of doctor rating websites, rather in addition to past experience of having used the internet for health purposes, there are more underlying motivational factors. For example, they need to be convinced that the feedback they leave about GPs online is needed by the GP, will be seen and valued by the GP, and will also help other patients.

Unlike existing academic work on OPF websites, the evidence from this study questions whether patients and carers really want or need OPF to give feedback about GPs in England. Only 4-5% of those who would consider leaving feedback in the future selected doctor rating websites as their most preferred method to leave feedback about a GP. Similarly, 82% of the public said they would not consider using doctor rating websites in the future to leave feedback for a GP, whereas only 24% said they would not consider giving feedback in general (using any method) about a GP.

The results from this study also suggest that GPs, GP practices, the NHS and feedback website providers need to consider alternative mechanisms to collect patient feedback in general practice, instead of solely relying on The NHS Family and Friends Test card and OPF websites. In particular, direct methods to give feedback to the GP or the GP practice (digital or non-digital) are most used and preferred by patients, such as face-to-face feedback, email, telephone, and private feedback forms on the GP practice website. Detailed recommendations based on the results of this study are provided in Chapter 9.

8.7 LIMITATIONS OF THIS STUDY

The strength of this study lay in its use of a well validated mixed methods population questionnaire whose aim was to measure representative views of the public on giving feedback about GPs on OPF websites, within the context of other feedback mechanisms. Nevertheless, this study did have several limitations.

Firstly the sampling method used – a random location quota sampling – was not a random sample, and although the data was weighted so that it would be a representative sample of the population in England, the sample may still contain biases, and claiming generalizability (external validity) across the whole population in England could be questioned. However, given that it was not feasible to get a random sample of the population in England, this was as close as possible to a true representative sample and very little correction of the results was needed to make them in line with The National Readership Survey (NRS), which uses random probability sampling (further details about weighting are in section 8.3.5). The interviews were also conducted face-to-face, which meant that there was very little risk of respondents misunderstanding the questions, and there was a lower risk of premature termination, as interviewers could keep respondents motivated.

Secondly, although the questionnaire had strong internal validity (as detailed in Chapter 7), the fieldwork was conducted by 150 interviewers from Ipsos MORI, and not the researcher, and this could be a potential weakness. Nevertheless, the interviewers were all experienced professional interviewers who were trained by Ipsos MORI and given the same very specific instructions. A validation procedure (as discussed in section 8.3.4) on the fieldwork was also conducted to ensure that interviewers had interviewed respondents as expected.

Thirdly, in relation to the attitudinal questions in the very final section of the questionnaire, almost a third of respondents selected 'neither agree nor disagree' to each question. It was not clear whether this indicated a lack of interest in the topic, response fatigue or that some respondents did not have a strong opinion about the topic in question.[9] Thankfully, the rest of the questionnaire did not have this issue, because the questions were not based on an attitudinal scale with the option to 'sit on the fence', and therefore the vast majority of the results do remain conclusive.

Fourthly, the results of this study question the value of providing OPF websites in England to give feedback about GPs; however, this study did not explore patients' views on OPF websites for choice, an issue that was outside the scope of this study. Although both giving feedback and patient choice are highly connected (because if patients do not give feedback or reviews online, other patients will not have these

[9] This is actually an advantage as the study is not skewed by strong opinions of a minority group.

patient reviews to choose from), they are distinctly different as actions. The results when reported in this study make clear that they are specifically about giving feedback to GPs only.

CHAPTER 9 - OVERALL DISCUSSION & RECOMMENDATIONS

9.1 INTRODUCTION

The findings from each of the studies have been discussed in detail in their respective chapters. Therefore, this chapter summarises the key findings that have emerged from all three studies by bringing together similar or contrasting findings, and highlighting the new evidence that has emerged from this research. This is followed by a discussion on the implications of the findings on NHS policy, future recommendations for OPF website providers and GPs/GP practices, and recommendations for future research. The chapter ends by reflecting on the research process, and discusses the strengths and limitations of the methodological approach used in this research.

9.2 KEY FINDINGS AND CONTRIBUTIONS OF THE RESEARCH

Academic literature as well as some stakeholders of OPF websites have argued for and against OPF (as detailed in Chapter 3), and this research has generated new evidence (see Table 9-1) that has expanded the evidence base by exploring how OPF is perceived by patients and GPs as a mode to leave feedback about GPs. The key findings from this research and their significance are discussed in this section.

In summary, evidence has been produced both in favour of and against OPF. However, it should be noted that evidence produced against OPF is in the form of surmountable barriers which can be overcome if the detailed recommendations provided in section 9.4 of this chapter are implemented.

Table 9-1: A summary of new evidence found for and against OPF* from this research

Evidence found in favour of OPF *(see section 9.2.1)*	Evidence found against OPF* *(see section 9.2.2)*
OPF as a feedback method crosses age, social and regional divides	GPs are critical of OPF, and the majority do not consider OPF as a mode of collecting feedback from patients
OPF websites fulfil a 'need' that other feedback methods do not	Only 0.36% of patients are using OPF websites to leave feedback about GPs
GPs believe encouraging OPF website use could make them appear more 'open'	The majority of patients prefer not to use OPF websites to leave feedback about GPs
GPs believe OPF could provide new insights	OPF is biased because it is not representative of patient experience
Patients who want to give OPF want to use different modes	OPF websites are not easier or more accessible for the majority of patients
Privacy and security of OPF websites are not the main reasons why many patients refrain from using OPF websites	The ability to remain anonymous when leaving feedback on OPF websites is not a unique advantage for patients
	GPs do not want their name disclosed online; whereas more than half of patients want to leave their GP's name online

**These are barriers that could be overcome if the recommendations provided in section 9.4 are implemented*

9.2.1 New evidence found in favour of OPF

OPF as a feedback method crosses age, social and regional divides – Study C (Chapter 8) found that the following people are more likely to consider leaving feedback about a GP in the future: females, those between the ages of 35-44, 55-59, and 60-64; those who have long term health conditions; those who have used the internet in the past to search for health information; and those with higher qualifications and those living in certain regions. From these, females and those with long term health conditions were also found to be more likely to have given feedback in the past about GPs, and those with long term health conditions were also more likely to be aware of the option to leave feedback about GPs. However, for future consideration of OPF website usage for giving feedback about GPs, only those who had used the internet in the past to search for health information were found to be more likely to consider using OPF in the future, suggesting that OPF websites cross age, social and regional divides (the predictors for future intention to use other feedback methods to give feedback about GPs), and appeal to everyone who takes an active interest in their own health, and is familiar with the internet to pursue that interest (see Table 8-1). This contradicts GPs' belief in Study A that younger patients are more likely to use OPF websites to give feedback; and also Galizzi et al.'s (2012) findings which reported income, ethnicity and the doctor-patient relationship as

significant predictors for future intention to use doctor rating websites (although not clear for which purpose/s).

The findings do appear to support Bardach et al.'s (2012) argument that OPF websites would collect feedback from those patients who would not normally give feedback. This suggests that OPF websites can be used by GPs, practices and the NHS to collect feedback from patient groups they would not normally get feedback from. On the other hand, it also suggests that OPF websites do not appeal to the majority of those (listed above) who are more likely to give feedback using other methods.

OPF websites fulfil a 'need' that other feedback methods do not – Previous research has not explored patients' attitudes or motivations regarding OPF websites (Powell et al. 2015)**.** The results of Studies B and C suggest that unlike the motivations for other methods, OPF websites are useful for those patients who have more altruistic motives, and want to help others, and this has been described in the field of e-consumer behaviour as 'altruism' (Parikh et al. 2014), and by Lupton (2013) as patients carrying out their 'citizen duty'. Study B also found that OPF websites were useful for those patients who wanted to place collective pressure on their GP/practice to improve, and this was additionally found to be a motivation for people leaving travel reviews by Yoo and Gretzel (2008). Furthermore, when patients were asked in Study C, 27% believed feedback left online would be taken more seriously by the GP or practice. These findings indicate that OPF websites are fulfilling a need that is not present in other feedback methods, indicating that the option of leaving feedback about GPs on an OPF website should be available for patients in England.

GPs believe encouraging OPF website use could make them appear more 'open' – More than half of GPs (13/20) in Study A upon questioning believed that encouraging their patients to use OPF websites would give the impression that they are more 'open', and it would improve their reputation. Reputation may be important to GP practices especially where there are multiple practices in close proximity, and giving patients the appearance that they are transparent as a practice was found to be perceived as advantageous by GPs. This finding was not expected; and was not found to have been reported before anecdotally in academic or non-academic literature. However, public reporting of performance measures has been argued to bring improvement because healthcare providers want to protect their reputation (Hibbard

et al. 2003), or because of concerns about retaining market share (Berwick et al. 2003).

GPs believe OPF could provide new insights – Almost half of GPs (n=9) in Study A believed OPF would provide new insights and perceptions about the needs of their patients (although only two mentioned that OPF could change their practice), and this was also mentioned as an advantage by an OPF website owner (Bacon 2009). Moreover, all of the GPs that participated in Study A believed that OPF website usage would increase over time. This suggests that despite GPs' criticism and scepticism about OPF websites (found in Study A), and physicians' criticisms of OPF found in the literature (Coombes 2009; Dolan 2008; Hotopf 2013; Lagu et al. 2010; McCartney 2009; O'Dowd 2009), GPs could be convinced of the benefit of OPF websites, if their concerns are addressed and some systematic changes are made to OPF websites (recommendations for changes are in section 9.4).

Patients who want to give OPF want to use different modes – Previous research has not explored how patients would like to leave feedback on OPF websites. Evidence from Study C indicates that among those who would consider leaving feedback on OPF websites, some patients want to leave feedback using alternative modes, and away from their personal computer. For example, by using apps or on paper-based feedback cards in the surgery.

This means that even those that do not have internet access can still leave feedback on OPF websites by using an alternative mode, suggesting that the multi-channel nature allowed by an OPF website is advantageous. CareConnect, piloted by the NHS, for example, was multi-channel (it allowed feedback through text messaging, twitter, telephone, as well as online) (Shah 2015). However, evidence from Study C suggests that some patients also want the option to leave feedback in the situated environment in real-time (i.e. whilst the patient is at the GP practice); using digital or non-digital methods (feedback from the latter could then be uploaded online). The ability of OPF to be multi-channel is therefore advantageous to the patient, and the need for 'real-time' feedback also supports NHS Policy which requires hospitals and general practices to collect 'real-time' feedback through the FFT (NHS England 2013).

It could be argued that an additional benefit of OPF is that OPF websites can be run by healthcare providers, commissioners or an independent third party (or multiple

stakeholders). However, results from Study C suggest that patients on the whole prefer to give feedback about GPs to the NHS (on an official channel), rather than an independent organisation, and this contradicts the findings of Davidson et al. (2010) who found that independently run OPF websites were perceived as more trustworthy by patients in England. Furthermore, GPs in Study A also suggested that GPs prefer an OPF website run by the government, rather than by an independent organisation.

Privacy and security of OPF websites are not the main reasons why many patients refrain from using OPF websites – One of the arguments that GPs proposed in Study A against OPF websites was that patients' own confidentiality could be at risk when they leave feedback on OPF websites, because they could inadvertently expose confidential information about themselves. Similarly, more than half of participants (10/18) in Study B from all age groups had concerns about privacy and security when leaving anonymous feedback online, whereas only two participants were concerned about their privacy when leaving feedback using the FFT card. This was surprising given that 61% of adults in the UK use social media (Ofcom 2015), and expose information about themselves online.

In contrast, in Study C, only 3% (20/673) of patients raised privacy or security concerns as one reason for not wanting to leave feedback on OPF websites; and more than half of all patients (51%) who would consider leaving feedback on OPF websites were happy to leave their full name online when leaving feedback about their GP. This suggests that on the whole, privacy or security is not the main reason why 82% of the public will not consider leaving feedback on OPF websites. Rather, results from both Studies B and C illustrate that patients are not convinced feedback is needed by GPs or will be used by GPs; and many are just apathetic towards giving feedback in general about GPs, regardless of the method of feedback (online or offline). This is similar to findings from Entwistle et al. (2003) who found that a 'significant minority' (around 5% for secondary care; and 1% for primary care) of Scottish patients said they would not give feedback (regardless of the feedback method offered) because they do not believe the healthcare provider will be responsive.

9.2.2 New evidence found against OPF

GPs are critical of OPF, and the majority do not consider OPF as a mode of collecting feedback from patients – A quarter of GPs were not aware of OPF

websites, and the majority of GPs interviewed (17/20) did not currently consider OPF websites as a way of collecting feedback from patients, and were choosing to ignore OPF. The majority of GPs also believed that OPF websites posed a risk to them because of false allegations that patients could make about them on such websites, and what they perceived was an absence of regulation of these websites. These concerns were also raised anecdotally by McCartney (2009), and the risk of online comments has additionally been reported in relation to patient bloggers commenting on healthcare professionals online (Speed et al. 2016).

GPs in Study A argued further that not only will OPF negatively affect GPs' reputation and well-being, but it will make them practice more defensively in the future, which is dangerous. The vast majority of GPs (16/20) also did not believe that OPF would force them to improve their performance out of fear of it affecting their reputation, as claimed by a previous health minister Ben Bradshaw (Carvel 2008).

Only 0.36% of patients are using OPF websites to leave feedback about GPs – Study C found that only 0.36% of patients had used an OPF website before, despite 15% of patients being aware of them. This is considerably low, given that the same study found that 19% of the population in England have given feedback in the past about GPs (using any feedback method).

Previous studies had not explored usage of OPF websites in England to specifically give feedback about GPs. Galizzi et al. (2012) found that 3% of their Londoners' sample (n=200) had used an OPF website before, but they did not specify for which purpose. The extremely low level of OPF website usage found in Studies B and C both suggest that patients are not using OPF websites to give feedback about GPs. This is surprising given that the NHS Choices feedback website has been live since 2008, and the NHS very recently spent £1.25M investing in a new OPF website called CareConnect (Shah 2015).

The majority of patients prefer not to use OPF websites to leave feedback about GPs – The greatest downside of OPF found in this research was that 82% of patients said they would not consider using OPF websites in the future to leave feedback about a GP, whereas only 24% said they would not consider giving feedback using any method. Moreover, only 5% (36/776) of patients selected OPF as their most preferred method to leave negative feedback about a GP, and 58% (490/844) of the

population would consider giving feedback about a GP using another method, but not using OPF websites (found in Study C). This is surprising given the popularity and increase in usage of consumer rating websites for products and services, including travel (Filieri 2014; Li et al. 2012; Schuckert et al. 2015).

Furthermore, both Studies B and C found that the majority of patients prefer direct and private methods to leave feedback about their GP, and this was also found by Entwistle et al. (2003) with Scottish patients (see section 2.4.2). In Study C, 45% of those who would consider leaving negative feedback about a GP preferred to give it directly to the GP, and a further 33% preferred to give it directly to the practice manager or to the practice. The vast majority of patients (93%) who had given feedback in the past had given it directly to the GP or practice. Previous research had not explored the level of future intention to use OPF websites in the future, nor how that compared to the future intention to leave feedback (about GPs) using other feedback methods.

Study C found that more patients prefer to leave feedback on a private form on a GP practice website than on a public website, which may suggest that some may be using doctor rating websites because of ease of use and convenience, but actually may prefer to use an online mode where feedback would remain private, instead of being posted in public. This is further supported by findings in the same study that illustrated that more respondents prefer to email a GP with feedback rather than write a letter. This on the whole questions patient need for OPF websites as a mode to leave feedback about GPs; and may question whether OPF is really fulfilling a 'feedback gap', as found in this research and confirmed by Bardach et al. (2012).

OPF is biased because it is not representative of patient experience – As discussed in Chapter 3, one of the main anecdotal criticisms against OPF websites is that the feedback left on them is not valid because it is not representative of the mainstream patient experience. This is because firstly usage is claimed to be too low; and secondly when feedback is left, it is claimed to be largely negative (Coombes 2009; Dolan 2008; Hotopf 2013; Lagu et al. 2010; McCartney 2009; O'Dowd 2009). These two concerns were also raised by the majority of GPs in Study A, who believed that OPF was seriously biased, and were worried about the impact OPF could have on them, on their practice, and their patients, who may use these 'questionable online ratings' to make an 'invalid choice' of which healthcare provider to use.

The latter (OPF is largely negative) has been dismissed with many studies showing that feedback on OPF websites is largely positive (Alemi et al. 2012; Black et al. 2009; Detz et al. 2013; Emmert and Meier 2013; Emmert et al. 2014; Gao et al. 2012; Greaves et al. 2012b; Kadry et al. 2011; Lagu et al. 2013, 2010; López et al. 2012). However, it is not known whether patients are equally likely to leave positive or negative feedback. GPs in Study A suggested that patients leave feedback on OPF websites when they have a negative experience; similarly, patients in Study B also suggested that they are mainly likely to leave feedback when they experience an extreme negative experience. However, they all said that this was regardless of whether the feedback was offline or online. In Study C, although the findings showed that patients were more likely to leave negative feedback using any method, almost half of the patients said they would leave feedback (using any method) for both positive and negative experiences equally. The preference of mode of feedback did change for both negative and positive feedback, as also found in Study B, but this was for all feedback methods, and not exclusive to OPF websites. Nevertheless, this does become pertinent when OPF is then used for choice by patients, because this would suggest that patients are using biased OPF to make a choice of provider.

The former claim (that patient usage of OPF is too low) was found by Galizzi et al. (2012) in a convenient survey-based study in London, and was also mentioned by GPs in Study A who claimed that the majority of their patients were not aware of OPF websites. Results of Study B suggested this was true, and showed that the majority of participants (16/18) were not aware of OPF websites, and only one person had used an OPF website to leave feedback. However, what was also found was that almost half of the participants did not know they could leave feedback for a GP using any method. Therefore in Study C, awareness, usage and future consideration of usage of any feedback method was explored, alongside OPF websites. The results found that awareness of OPF websites (at 15%) is not too low when compared to awareness of the option to leave feedback in general (at 39%). However, as discussed above, usage of OPF websites (at 0.36%) and future consideration to use OPF websites was very low (at 18%), especially when compared to usage of any other method of feedback (at 19%), and future consideration to use any other method of feedback (at 76%). The results therefore indicated that usage was indeed very low, but what was more surprising was that 58% of the population would give feedback using another method, but not using OPF websites.

This, as well as the different predictors found in Study C for awareness, usage and future consideration to use OPF websites (see Table 8-1), all suggest that feedback on OPF websites is not likely to be representative of the patient experience in the near future. Although this may not be a pertinent problem for GPs and GP providers using the patient experience data for improvement (because improvement even based on one piece of patient feedback could potentially be useful), fundamentally it is a huge problem for the use of OPF for selection (i.e. patient choice), and for monitoring. This is because the results strongly suggest that OPF is biased because it is not representative of patient experience, and therefore patients using OPF for choice of healthcare provider are basing their choice on biased and unrepresentative data, challenging strongly the popular notion that OPF is useful for patient choice, as advocated both by academics (Greaves et al. 2012b; Lagu et al. 2013; Trigg 2011) and the NHS (Lansley 2012; NHS Choices 2016).

Furthermore, the findings appear to contradict Greaves et al.'s (2012b) observation of associations between NHS Choices general practice ratings and patient experience measures, thus strongly questioning the usefulness of OPF as a measure of quality in healthcare.

However, others in the literature have argued that OPF is still useful for improvement (through concerns over protecting reputation), even if it is not representative of patient experience and therefore biased, because it can be used as a complementary measure to other measures of patient experience (Greaves et al. 2013a; Lagu et al. 2013). But findings from this research suggest that GPs do not consider OPF currently as a patient feedback mode, and are not using OPF to make changes to their practice; rather, they are choosing to ignore OPF. This is unlike retailers and hotels, who are taking reviews written about them online very seriously (Filieri 2014; Li et al. 2012; Schuckert et al. 2015). For example, on Trip Advisor, hotel managers commonly respond to reviews written about their hotel. Furthermore, consumers are taking advantage of that, to the extent that they are now using social media to not only complain about poor service, but place collective pressure on retailers (BBC 2016).

Results from both Studies B and C indicate that low usage of OPF websites could be reversed if the GP or GP practice asked patients to leave feedback online, and indicated to patients that their feedback is needed or wanted by patients. Furthermore, this would also remove patients' concern (found in Study B) that they

are unsure whether feedback left on OPF websites will reach the GP. However, the majority of GPs in Study A suggested that they would not ask their patients to leave feedback on OPF websites. Instead, the majority of GPs did say they would use OPF to improve their practice, as long as the feedback was true. They were also keen on seeing systematic changes made to OPF websites that would protect their privacy and reputation.

OPF websites are not easier or more accessible for the majority of patients – All of the GPs in Study A believed that their younger patients would prefer OPF websites for giving feedback because they would find them easier to use than other feedback methods. Entwistle et al. (2003) also found with a group of Scottish patients that a few of them (<0.9%) perceived it easier to leave feedback on a website. In contrast, in Study C, although 11% (19/171) cited ease and convenience as the reason for considering leaving feedback on OPF websites, 43% (vs 24%) of respondents (n=844) disagreed that giving feedback online would be easier than a feedback form at the surgery. Similarly, in Study B, although almost half of participants (n=7) (all under the age of fifty) believed that websites are more accessible because they are available all the time and can be used anywhere, more than half the participants (n=11) from all age groups expressed that websites were less accessible. The evidence thus suggests that although some patients may find OPF websites easier to use than other methods, the majority would find other methods easier to use. However, it must be noted, as mentioned previously, that OPF has the ability to be multi-channel, so accessibility barriers of OPF websites can be easily eliminated.

The ability to remain anonymous when leaving feedback on OPF websites is not a unique advantage for patients – GPs in Study A believed that the ability to give feedback anonymously may benefit patients, and this was also cited as an advantage of OPF websites by López et al. (2012). However, GPs in Study A, and 13 healthcare professionals in Speed et al.'s (2016) study argued that anonymous feedback was difficult to use for improvement, a problem also highlighted by some patients in Study B. Crucially, only 2% (4/171) of patients in Study C cited anonymity as their reason for considering giving feedback on OPF websites; and more than half of all patients (51%) were happy to leave their full name online when leaving feedback about their GP. This contradicts findings from Speed et al. (2016) who found in their qualitative study with 10 health blogger patients and 18 patient representatives (in

England) that patients wanted to remain anonymous, due to the fear of being identified by healthcare practitioners and the implications on their future care.

GPs do not want their name disclosed online; whereas more than half of patients want to leave their GP's name online – Unlike consumer rating websites like Trip Advisor where managers or other key personnel can be named, GPs remain anonymous on the NHS Choices website (a practice-based OPF website). GPs in Study A, despite acknowledging that practice-based anonymous feedback left online is not easy to use (because it is anonymous), the majority of them preferred to receive this type of feedback instead of physician-based individual feedback, because it made them feel less vulnerable. This sense of vulnerability was also discussed by McCartney (2009) and found by Speed et al. (2016) in their qualitative study with healthcare professionals. The majority of patients in Study B also wanted to protect their GP's privacy and were not keen on exposing their GP's name online. However, in Study C, 60% (214/354) of those who would consider using a doctor rating website for any purpose in the future said they would mention their GP's name when leaving feedback on OPF websites.

9.3 IMPLICATIONS OF THE FINDINGS FOR NHS POLICY

As discussed in detail in Chapter 3, NHS policy has argued that OPF provides a rich source of transparent data about patient experience which can improve healthcare outcomes (Lansley 2012; NHS England 2013; The NHS Confederation 2012) and can be used by patients to choose a healthcare provider (Department of Health 2003; Fotaki 2014).

The most recent NHS policy which makes mention of an OPF website for collecting patient feedback is the *Transforming participation in health and care* guide for commissioners from NHS England (2013), which framed OPF websites as a tool that gives an insight into improving patient experience, health outcomes and health services:

> *"By listening and learning from patients, carers and their families, both when things go well and when they go badly, we can understand what we need to do to improve their experience. This can be achieved through feedback methods ranging from complaints, social media, the Friends and Family Test (see case study here) and feedback websites such as CareConnect or PatientOpinion." (Page 43)*

The findings from this research suggest that OPF websites appear to be filling a 'feedback gap' by collecting feedback from those patients that may not give feedback using other methods; and that unlike other feedback methods, OPF websites are relevant across age, social and regional divides.

Yet findings from Study C also suggest that only 0.36% of patients are using OPF websites to leave feedback; and that OPF, as it currently stands, is biased towards negative experiences and not representative of patient experience because of extremely low usage. It could be argued that this feedback, however biased towards the negative or unrepresentative in nature, could still be useful for improvement purposes; however, Study A found that GPs are not currently using OPF for improvement purposes unless systematic changes are made to the OPF websites first (see section 9.4 for detailed recommendations).

The bias and unrepresentative nature of OPF could be reversed if OPF websites were promoted more amongst patients and GPs, and patients were asked specifically to leave feedback, so that there is more feedback from patients on OPF websites. Similarly, the findings suggest that if patients were encouraged to leave feedback on OPF websites, their preference could change, and this is further supported by the findings from this research that patient feedback could be doubled if GPs or the GP surgery asked patients to leave feedback about GPs.

As outlined in section 3.1, the most recent NHS policy on feedback and complaints (Department of Health 2015b, 2015a) does not ask GPs and GP practices to promote OPF to patients, or to use OPF to bring improvement or change. It could be argued that this partially explains why OPF website usage by patients and GPs was found to be extremely low in this research.

NHS policy also needs to consider that the majority of patients (77%-78%) prefer to leave feedback about GPs directly with GPs, the practice or practice manager (45% preferred leaving negative feedback directly with the GP; 16% preferred the practice manager; 17% preferred the practice). In contrast, only 5% of patients' most preferred feedback method for reporting negative experiences was an OPF website.

Giving feedback directly to the GP or practice manager is not advocated in current NHS policy (Department of Health 2015b, 2015a), and the only direct feedback method for GP practices advocated in policy is the Friends and Family Test (FFT) (see

section 2.4.1). However, a paper-based feedback card (the most common way FFT is implemented) was not found to be popular amongst the patients in this research, with only 10% of patients selecting it as their most preferred method to leave negative feedback.

Although choice was not the focus of this research, the findings do strongly challenge the notion that OPF is useful for patient choice, as advocated by policy makers (Department of Health 2003; Fotaki 2014). The research found that OPF is biased towards negative experiences and not representative of patient experience. This means that patients using online patient reviews to choose a healthcare provider could be making an invalid choice; and therefore the suggestion that OPF can improve healthcare outcomes (through the selection pathway) is questionable.

This means that the 'patient choice' part of the NHS Choices website must contain patient feedback narratives collected through other methods. Based on GPs' concerns and suggestions in Study A, other scores should also be included, such as ratings of the GP's professional competence, CQC ratings or safety scores. However, the recommendation is that 'OPF for feedback' and 'OPF for choice' both remain on the same website (and are not separated). This is because a major motivation among patients to leave feedback on OPF websites was found to be altruism (so that others can see what went right or wrong; and change can be made which will benefit other patients too), and the ability to place collective pressure on healthcare providers.

9.4 RECOMMENDATIONS FOR PRACTICE

This research has produced recommendations for the two key stakeholders involved with OPF: OPF website providers/owners, and GPs and GP Practices, as shown in Figure 9-1.

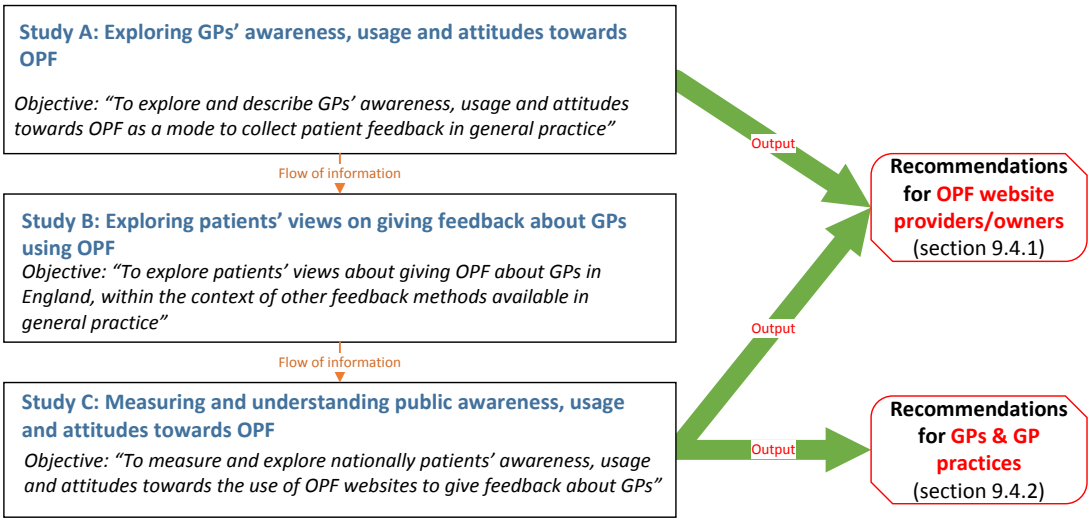


Figure 9-1: Recommendations as outputs from the studies

9.4.1 Recommendations for OPF website providers/owners

Based on outputs from Study A and Study C, the following three major recommendations were produced for OPF providers in England (NHS England and other independent providers):

A. Make systematic changes to OPF websites – see Table 9-2
B. Positively promote and convince patients and GPs about the value of OPF – see Table 9-3
C. Make OPF websites accessible to all patients – see Table 9-4

Where the recommendation is from Study A alone, it has been marked with an asterisk (*) in the tables.

Table 9-2: Details about the recommendation to make systematic changes to OPF websites

A. Make systematic changes to OPF websites	
1	Allow patients to leave feedback on OPF websites, but when the feedback is presented to other patients for 'choice', it must be part of a collection of measures including patient feedback collected using other methods, and other measures such as the clinical competency of the GP, findings from the CQC report, and safety results. All of these must also be combined with the overall 'star rating' that is displayed for each GP or GP practice. Patients cannot exercise 'choice' accurately based alone on patient feedback left on OPF websites.
2	Consider allowing the patient the option to leave or not leave a GP's name when giving feedback online.
3	To eliminate concerns about patients judging a GP or a practice based on just a handful of reviews, have a larger number of reviews (for example, at least 20) on the website per practice before the overall rating is calculated and shown.*
4	Validate that the patient leaving feedback on the OPF website is registered as a patient at the given practice, through for example asking the patient for his/her NHS number. The NHS number could be concealed from the practice to protect the identity of the patient.*
6	Allow patients to leave feedback both for individual GPs and for the practice.*
7	Make patients aware that feedback and ratings left by other patients on these OPF websites may be primarily based on bedside manners, and that the majority of patients do not have the ability to judge the professional competence of a GP.*
8	Consider showing patients what changes have been made as a result of their feedback. This may convince them that their feedback is reaching the GP and is of some use to the GP.

Table 9-3: Details of recommendations to positively promote and convince patients and GPs about the value of OPF

	B. Positively promote and convince patients and GPs about the value of OPF
1.	**Use targeted marketing material (or provide information) both on the website and elsewhere to positively promote OPF websites to patients and carers:**
1a)	Make the public aware of OPF websites, because very few patients were aware of specific OPF websites. A national campaign to promote OPF websites will help increase the number of patients and types of patients leaving feedback and reviews, and therefore the feedback left online is less likely to be biased and unrepresentative. This will mean patients will be able to make a valid 'choice', and may also mean that GPs will take OPF more seriously. The promotion could be conducted through traditional marketing routes through GP practices, as well as digital methods, such as social media, TV ads etc.
1b)	Convince patients and carers that feedback they leave i) will reach the GP, ii) is needed by the GP, iii) will be used by the GP for improvement, and iv) will be useful to other patients to decide which GP to see or which GP practice to join.
1c)	Marketing material or techniques used could be focused on those who are less or more likely to leave feedback about GPs. Those that are more likely include: females; those between the ages of 35-44, 55-59, and 60-64; those who have long-term health conditions; those who have used the internet in the past to search for health information; and those with higher qualifications.
1d)	Target the majority of the marketing material to be left in GP surgeries. This is advantageous, firstly, because this means patients who are using the service are targeted directly whilst they are in the healthcare setting, and secondly patients are twice as likely to leave feedback when the GP or the GP surgery asks them to. Therefore, leaving material at the GP surgery may suggest to patients that OPF websites have the GP's or GP practice's approval.
1e)	Convince patients that the website is secure and anonymity will be retained.
2.	**Use targeted marketing material to positively promote OPF websites to GPs and GP practices.** This will help reduce misunderstandings about OPF amongst GPs, which will help increase usage of OPF by GPs and also by patients, because the findings suggest that patients are twice as likely to leave feedback when the GP or GP surgery asks them to. GPs could also be asked to endorse doctor rating websites to patients, and their endorsement could be used in marketing material.
2a)	The promotion of OPF could be done through GP training, or may even be as simple as creating a document entitled 'A guide to OPF [specific website name] for GPs' and signpost it well, both online and offline.*
2b)	Convince and reassure GPs about the value of OPF by outlining precisely how feedback left on the website is moderated and regulated, especially in relation to malicious or personal comments about individual GPs. Outline on the website and in any marketing leaflets what GPs can do with feedback that is left online for them, in particular how to respond to the feedback and use it for improvement.*

Table 9-4: Details about the recommendation to make OPF websites accessible to all patients

C. Make OPF websites accessible to all patients	
1	**The website should be designed so that it is easy and straightforward to use (user friendly), and easily accessible. This includes ensuring that the website is easy to use with all smartphone devices, and is also disability and age friendly.**
2	**Provide optional alternative methods and modes to leave feedback on OPF websites:**
2a)	Provide alternative modes to giving feedback on OPF websites, such as paper feedback forms at the GP surgery that could be used by patients, posted to OPF website providers, or given back to the GP surgery and then be placed online. This would be especially useful for those patients who do not have internet access or cannot use a website but are happy to share their feedback online, or those who want to give feedback whilst they are situated in the practice, but do not have a smartphone or access to the internet.
2b)	Consider providing an option on the website to directly contact the GP (for example, the option to email the GP from the OPF website if the GP has consented to that), or the option to leave feedback on an OPF website that will not be published but would be forwarded on to the GP or the GP practice.
2c)	Current evidence does not suggest that creating a separate app to leave feedback on doctor rating websites will rapidly increase usage. However, if patients are already using an app to book appointments for example, consider integrating a feedback function on to that.
2d)	Kiosks or iPads could be provided to patients at the GP surgery as an alternative method to leave feedback. This may encourage a few patients to give feedback, and it is something OPF website providers should explore further with GP practices and patients.
2e)	There is no need currently to invest in social media as a platform for collecting patient feedback about GPs. This may however change in the future.

9.4.2 Recommendations for GPs and GP Practices

Two types of recommendations were produced for GPs and GP practices based on findings from Study C:

A. General recommendations related to collecting patient feedback – see Table 9-5
B. Recommendations specific to OPF websites (or doctor rating websites) – see Table 9-6

Table 9-5: List of recommendations related to collecting patient feedback

A. General recommendations related to collecting patient feedback	
1	**Promote giving feedback about GPs to patients:**
1a)	Make patients and carers aware that they can leave feedback about and for GPs. The material or techniques used for marketing could focus on those who are more or less likely to give feedback about GPs. The following are more likely to leave feedback: females; those between the ages of 35-44, 55-59, and 60-64; those who have long term health conditions; those who have used the internet in the past to search for health information; and those with higher qualifications.
1b)	Patients need to be actively convinced that i) the method/s provided to leave feedback will ensure that the feedback will reach the GP, ii) feedback is wanted by the GP and will be useful to the GP, and iii) where appropriate changes will be made based upon the feedback.
1c)	Ask patients for feedback. The results indicate that patients are twice as likely to give feedback if they are asked by the GP or GP surgery to leave feedback.
2	**Examine the methods provided to patients to give feedback:**
2a)	There is no one feedback method that is preferred by the majority of patients, therefore the GP/practice should consider providing a few methods of feedback, based on consultations with their patients.
2b)	The methods that GPs and GP practices provide for patients to leave feedback about a GP need to be easy and convenient to use.
2c)	Where possible, provide direct method/s for patients to give feedback about GPs, including the option to email the GP directly. This is because half of those who would consider giving feedback about GPs prefer to give it directly to the GP, and email was preferred by more patients than writing a letter.
2d)	Consider alternatives to the NHS Friends and Family Test (FFT) card to get feedback from patients (because only 10% of patients who would consider leaving feedback selected paper-based feedback as their most preferred method to leave negative feedback about GPs).
2e)	There is no need currently to invest in social media as a platform for collecting patient feedback about GPs. This may however change in the future.
3	**Allow patients to leave feedback anonymously both on feedback cards and any other methods used to collect feedback.**

Table 9-6: List of recommendations specific to OPF websites

	B. Recommendations specific to OPF websites (or doctor rating websites):
1	To increase the number of people giving feedback on OPF websites, the GP/practice needs to: i) make patients aware that such websites exist, ii) convince them that they are secure and easy to use, iii) convince them that the feedback will be useful to GPs and to other patients, iv) and convince them that the GP will read and use the feedback for improvement. Feedback cards should also be provided at the surgery that patients can use to write feedback with a pen, which can then be uploaded online.
2	Alternatively if GPs/practices do not want patients to use OPF websites, they should provide clear alternative ways (digital and non-digital) for patients to give feedback about GPs, including direct ways to leave feedback, such as an email address for the practice/GP, or an easy to use private feedback form on the GP practice website where patients can leave feedback anonymously.
3	If some of the patients are already using an app to make appointments for example, consider integrating a feedback function on that app.
4	Kiosks or iPads could be provided to patients at the surgery to encourage patients to give feedback. However, evidence suggests that it will not dramatically increase usage of OPF websites.
5	If one of the aims is to increase patient choice by collecting patient feedback, GP practices could collect patient feedback using non-online methods, and then place that feedback online, which other patients can then use to choose a provider.

9.5 RECOMMENDATIONS FOR FURTHER RESEARCH

Based on the findings from this research and a review of the literature presented in Chapter 3, a number of future research opportunities can be identified, some of which are discussed below.

Transferability of the findings – Future research could explore whether the findings from this research apply to giving feedback about other healthcare professionals or services, such as secondary care. Future studies could also explore whether other doctors in England and elsewhere feel the same way about OPF as the GPs in Study A, and what impact this could have, if any, on the future of OPF websites.

Patient choice – Apart from a platform to give feedback, OPF websites were created to enable 'choice'. Future research could explore whether patients are using OPF to choose a healthcare provider, whether they believe OPF is useful for choice, or whether they prefer other ways to choose a provider. Patients' use of OPF could also

be explored to understand how OPF is evaluated and understood by patients, and to determine whether patients are able to use OPF to make a valid selection (choose a provider).

Explore content of OPF related to general practice feedback – Studies have analysed and explored the content of OPF left for secondary care (see section 3.3.7). Future studies could explore the content of the feedback left for primary care on the NHS Choices website and determine what type of sentiment is expressed in the feedback (is it about care, environment, service provision, bed-side manner, treatment?), who the feedback or review is left for, and whether the feedback is useful to GPs and GP practices for improvement.

A few of the GPs in Study A commented that it was not possible to reply to patient comments without violating patient confidentiality. Lagu et al. (2010) suggested that many of the patients' complaints on OPF websites could be addressed without violating patient confidentiality, as the comments were along the lines of: "not enough parking, didn't spend enough time, waited too long". Whether this is the same for the comments left for GPs and GP practices in England needs to be explored.

Similarly, some GPs in Study A were particularly worried about allegations and inflammatory remarks that patients could leave about them. Future research could explore the negative comments left on NHS Choices and identify how many of them, if any, could be categorised as 'inflammatory remarks', and whether identifiable information related to GPs and other staff in the practice, such as age, background, ethnicity, colour of skin etc. remain in the comments or not.

Responding to patients' comments online – GPs in Study A disagreed whether GPs should reply to comments left about them. A study by Lagu et al. (2013) analysed comments left for hospitals on the NHS Choices website and found that replies had increased to 56%. However, they also found that 64% of those replies were not actually 'responsive', in that they did not describe specific changes the hospital made or intended to make as a result of those comments. Further research is required to determine the extent to which GPs or GP practices are responding to feedback left on NHS Choices, and how many of those replies are 'responsive'. Future studies could also explore whether patients expect a response to the feedback they leave online, how a responsive or a non-responsive response would make them feel. Also, if

patients received or did not receive a reply, would that change their perception of the practice or GP and/or would this encourage them to place a formal complaint?

Using OPF for quality improvement – Although most of the GPs in Study A were happy in principle to use OPF for improvement, if the popularity of OPF grows among patients, research is required to explore whether OPF is actually being used by GPs and practices for quality improvement and how. Davidson et al. (2010) explored feedback on the Patient Opinion website and found that it was very difficult to get evidence on whether actual changes had been made as a result of the feedback. Further research could also explore whether other stakeholders such as CCGs, NHS England, and CQC are using OPF to monitor GPs' and GP practices' performance and how; and whether GPs and GP practices feel more accountable (and have improved) as a result of that. This can help determine whether OPF websites are contributing towards quality improvement in healthcare.

Feedback on social media – The findings from this research suggest that patients and GPs have little interest in using or promoting social media to leave feedback. There is some evidence to suggest that social media is being used by patients to leave feedback about hospitals (Greaves et al. 2014b). Future research could explore how much feedback is left for GPs and GP practices on various social media platforms, and how useful that may be for GPs and GP practices, to help determine whether social media needs to be offered or promoted as a channel for feedback by healthcare providers. Furthermore, studies could also explore the type of patients leaving feedback on social media, as well as the motivations for patients to use social media rather than other feedback methods.

The impact of privatisation on OPF – As the future of the NHS becomes threatened by privatisation (Iacobucci 2014; O'Dowd 2016a), future research could explore whether paying for healthcare means patients are more likely to use OPF websites for choice and feedback, and whether privatisation may transform the prevalence, use and nature of OPF websites.

9.6 LEARNING FROM THE RESEARCH PROCESS

9.6.1 Strengths and limitations of the research approach

The methodology used for this research has been discussed and evaluated in detail in Chapter 4; and limitations for each of the studies are discussed in detail in their respective chapters. This section summarises the key strengths and limitations of the overall research approach.

The research design (a multi-phased mixed methods design) – This research used a multi-phased mixed methods design to answer the research question, with each study building on from the previous study, because as illustrated in Chapter 3, there were very few academic studies published on OPF by 2011 when the research was first designed. This approach was therefore a strength because it meant that findings from Study A were explored in Study B, and findings from Study B were explored in Study C, generating new evidence as the research progressed.

The use of qualitative methods to explore the views of GPs and patients in Study A and Study B meant that the findings addressed some of the evidence gaps identified in literature (see Chapter 3). Using a population questionnaire in Study C meant that a nationwide representative view of the public about OPF was sought for the first time in England. The mixed method design of Study C also meant that qualitative findings were used to explain some of the quantitative findings, giving a richer and deeper understanding of OPF websites, and how they are perceived by patients. Findings from all three studies (from both qualitative and quantitative sources) produced evidence both in favour of and against OPF (as detailed in section 9.2), and shaped recommendations (see section 9.4) which can help overcome barriers to the use and validity of OPF.

Reliability and validity – Multiple strategies were used during the different phases to address the reliability and validity of the findings. In the qualitative studies (Studies A and B), the topic guides used for the interview were checked by the researchers' three supervisors prior to the field work to ensure there was no bias in the content or wording of the questions. The topic guides were also piloted to ensure that the questions were not cumbersome, and had not been misinterpreted by participants. Furthermore, when the interviews were analysed, codes were double checked, and the coding frame was also checked by the supervisors to ensure the

interviews were analysed accurately, and there was no bias in the analysis. A random sample was also attempted for Study A (albeit not entirely successfully), and a purposive sample for Study B, to ensure people from all ages were included in the study.

For Study C, in Phase 3 of the research (see Chapter 7), the questionnaire underwent seven stages of rigorous validation; including multiple expert reviews, cognitive interview testing and multiple stages of piloting with the public. This was conducted to ensure that the questionnaire was valid, accurate and reproducible, and there was no measurement error (Groves et al. 2009; Leeuw et al. 2008). When the interviews were conducted, 13% of the interview data was validated (back-checked), and no errors were found (see Chapter 8; section 8.3.4). The analysis of the results were double checked by the researcher, and the analysis plan as well as one of the logistic regression calculations was checked and approved by an academic statistician. Triangulation was also used to increase the validity of the research in Study C, where open ended questions were used to explain responses to closed questions.

Generalisability of the findings – The aims of the qualitative studies (Studies A & B) were not to achieve generalizability; rather the focus was on getting data that reached thematic saturation (O'Reilly and Parker 2012). Therefore, the findings from both of these qualitative studies are not generalizable to the population at large, and these are acknowledged as limitations of the studies. In contrast, Study C was a large mixed methods questionnaire study, which was conducted with a focus on generalizability. Although there were limitations to the sampling method used (a random location quota sampling) as discussed in detail in section 8.7, it was not feasible to get a random sample from the population, and this approach was as close as possible to a true random sample. The study was conducted with 844 members of the public, and with very little corrective weighting the sample was representative of the population in England (see section 8.3.5). This study therefore provided the first conclusive evidence on patients' perspectives on OPF websites (in England).

Perceived future use and motivations – In all three studies, where questions were asked about future intention to use OPF websites and motivations for future use, this may not be reflective of actual future action, as these were perceived motivations and perceived future intention to use. Participants were nevertheless asked about current

usage and past experience of OPF websites and other feedback methods, in all three studies.

9.6.2 Personal reflections on the research

The plans for this research were first conceived in 2011, when there was very little academic literature on OPF. This was advantageous because it meant that the research was truly exploratory, without existing theories or biases affecting it. However, many studies were published during the period of 2012-2015, and this meant that as the research progressed, new findings from the literature had to continuously be incorporated into the design, scope and discussion of the studies. The rapid growing academic interest in OPF did signify the importance of this topic, which was reassuring.

A significant number of challenges were faced when recruiting GPs to take part in the research in Study A, and these have been discussed briefly in section 5.2.3. The learnings from this experience have been detailed in a peer-reviewed published case study (Patel et al. 2017). In brief, multiple recruitment strategies had to be used to recruit GPs to participate, despite financial incentives being offered. OPF was also quite an emotive subject for GPs, and hence one had to be very careful to come across as neutral as possible.

The decision as to which mode to use to conduct the nationwide survey was not taken lightly, and multiple experts were consulted before a decision was made. It was a difficult decision to make because 'random sample' modes are generally given priority; however, there were other pragmatic considerations, such as the budget. Based on findings from Study B, it was also known that OPF was not a popular topic amongst the public, and therefore response rates, if for example a random postal survey was sent out, would be extremely low (below 5%), and the benefit of conducting the survey randomly would be eradicated.

The scope of the research was limited due to pragmatic reasons, because although it explored patients' perspectives on using OPF as a mode to give feedback about GPs, it did not explore the use of OPF for choice, nor the use of OPF to give feedback about other healthcare professionals. This could be explored in future studies. Moreover, this research is the largest and most robust study to date on OPF in England, and the

evidence and recommendations produced from the research provide a valuable contribution to the field.

CHAPTER 10 - CONCLUSIONS

This research addressed the questions: *'Are patients and GPs aware of online patient feedback websites as a channel for experiential feedback, and do they use them? What are their attitudes towards them? What are the implications of this for policy and practice?'* This chapter summarises the key findings, and ends by highlighting the main contribution of this research.

Summary of GPs' awareness, usage and attitudes towards OPF websites

Although criticism of OPF websites by physicians has been reported anecdotally in the literature (see section 3.3.8), previous research has not explored healthcare professionals' awareness, usage or attitudes towards OPF websites. This research therefore explored this, and found that GPs in England have limited knowledge and awareness of OPF, and less than a quarter of GPs would ask their patients to leave feedback about them online.

Furthermore, GPs had serious concerns and reservations about OPF, and they questioned the validity of OPF because of: data and user biases; the usability of OPF due to the feedback being anonymous; the transparency of OPF because of the risk of false allegations and breaching confidentiality; and the resulting impact of all those factors on them, their professional practice, and their relationship with their patients. The majority of GPs did not consider OPF websites as a channel for collecting patient feedback in general practice, and were choosing to ignore OPF.

Despite this, half of the GPs believed that OPF does have the potential to provide new insights on the needs of their patients, and the majority of GPs were happy to use OPF to improve their own performance, on the condition that systematic changes were made to OPF websites, such as verifying that a review was left by a patient of theirs. Similarly, less than a quarter of GPs called for the OPF websites to be completely scrapped. Furthermore, all of the GPs agreed that OPF websites would be an easier way for their younger patients to give feedback, and most GPs agreed that OPF will get more popular as the younger generation gets older. This suggests that GPs could be convinced of the value of OPF, if their concerns about OPF websites (listed above) were addressed by OPF website providers. The specific changes required are detailed in section 9.4.1.

Summary of patients' awareness, usage and attitudes towards OPF websites

This research explored patients' awareness, usage and attitudes for both OPF websites and other feedback methods available in general practice in England. This was to allow for adequate comparison and a more comprehensive understanding of public awareness and usage of OPF websites, rather than an isolated one, as previous researchers in this field had conducted (Burkle and Keegan 2015; Emmert et al. 2013a; Galizzi et al. 2012; Hanauer et al. 2014b; Terlutter et al. 2014). These researchers also explored the effect or association of socio-demographic and health factors on the usage and awareness of OPF websites, and used some of the factors to explain the variance in results. This was also conducted in this research; however, this research went a step further and explored the attitudes, motivations and barriers to usage of doctor rating websites, and how this compared to attitudes, motivations and barriers towards other methods. This research was also unique because it focused specifically on using OPF websites to give feedback about GPs, whereas all of the previous studies (cited above) explored OPF websites more generally (for feedback and for choice), and asked respondents to comment on its overall use for all healthcare services.

Patient awareness of OPF websites as a channel to leave experiential feedback about GPs was found to be low at 15%; however, usage and future consideration to use OPF websites was found to be extremely low, with current patient usage at just 0.36%, and patient intention to use OPF in the future at 18%. Furthermore, more than half of patients said they would consider leaving feedback about GPs using another method, but not using an OPF website.

The barriers to patient usage of OPF websites were found to be:

a. Apathy towards feedback, where patients do not want to leave feedback about a GP, regardless of which method of feedback was offered to them
b. Preference to use another method of feedback
c. Concerns about OPF websites (including accessibility, validity of reviews, or security and privacy concerns)

Conversely, patient motivations to use OPF websites were found to be:

1. Opportunity to assist GPs to improve their performance
2. Ability to share feedback and help other patients
3. Ease and convenience of using a website

4. OPF websites could be more private, and they could remain anonymous
5. Feedback left online may be taken more seriously by the GP or the GP practice

This suggests that although some patients have a few specific concerns about OPF websites, OPF websites are also uniquely advantageous for some patients (points 2-5) and are fulling a 'feedback gap'. Furthermore, OPF as a feedback channel was found to cross age, social and regional divides (see section 9.2.1), because unlike other feedback methods, previous use of the internet in the past to search for health information was found to be the only predictor of future usage of OPF websites to leave feedback about GPs. This contradicts GPs' belief that younger patients are more likely to use OPF websites to give feedback; and also Galizzi et al.'s (2012) findings from London which reported income, ethnicity and the doctor-patient relationship as significant predictors for future intention to use doctor rating websites (although the purpose of use was not specified). The findings appear to support Bardach et al.'s (2012) argument that OPF websites would collect feedback from those patients who would not normally give feedback.

The research also found that among the patients who would consider leaving feedback about GPs in the future, only 4%-5% of them most preferred to use OPF websites as a mode of feedback. In comparison, the majority of patients (77%-78%) preferred to leave feedback directly with the GP, practice or practice manager with almost half (45%-51%) preferring to leave feedback directly with the GP. 93% of patients who had given feedback in the past had given it to the GP or practice. This appears to support Entwistle et al.'s (2003) findings which suggested that the majority of Scottish patients prefer to raise concerns about poor care from a GP, with GPs themselves. However, this contradicts the popular opinion that patients would not risk jeopardising their relationship with their GP (Dorr Goold and Lipkin 1999), but does support the notion that the emphasis on patient-centred care has meant that patients are increasingly seeing their relationship with their GPs as more equal (Kaba and Sooriakumaran 2007).

Summary of the implications of the key findings on policy and practice

OPF websites as a channel for collecting patient experience feedback in general practice – The evidence found in this research questions and challenges whether patients and GPs really want or need OPF websites to give feedback about

GPs. This is because GPs were found to be highly critical of OPF; very few patients had used OPF websites or would consider using OPF websites in the future to leave feedback about GPs. Altogether this suggests that OPF websites may not be an effective channel for collecting feedback on patient experience in general practice. The NHS must provide alternative methods of collecting feedback.

The findings do not support the popular view that patients who are online find it easier to leave feedback on OPF websites (rather than through other methods), and that the anonymity provided by OPF is perceived as advantageous to patients, as argued by López et al. (2012) and Speed et al. (2016). Rather the majority of patients in this research were surprisingly not concerned about their privacy when leaving feedback online, and were happy to leave their real name online. Instead, the two major reasons for choosing one mode of feedback over another were i) ease and convenience, followed by ii) the method being a direct way of giving feedback. These are interesting findings, because currently there is little formal provision in general practice in England to give feedback directly to GPs.

Nevertheless, the findings do suggest that OPF websites fulfil a 'feedback gap' for a small number of patients, and appear to support the argument that some patients, who would not normally give feedback using other methods, would leave feedback on OPF websites, as detailed on the previous page. Therefore, this suggests that OPF websites could be used to improve patient experience, as feedback can be collected from those patients who may not give feedback using other channels. The recommendation would therefore be that OPF websites are improved to address the problems found through this research (see section 9.4.1 for detailed recommendations). GPs should then be asked to promote the websites to their patients, since this research also found that GPs can double the volume of feedback if they ask their patients to leave feedback.

OPF as a source of improvement in general practice – As discussed above, this research found that OPF can be used to collect feedback from a very small minority of patients who may not give feedback through other methods, suggesting that OPF could be used to bring improvement through individual patient feedback (albeit from a very small group of patients).

However, OPF is not likely to be used currently by GPs to improve their professional practice because this research found that the majority of GPs did not consider OPF as a valid nor potential source of patient feedback; they had serious concerns and reservations about OPF; and were ignoring OPF, which supports physicians' criticisms found in the literature (see section 3.3.8). Furthermore, a quarter of GPs were not even aware of OPF websites. However, unlike the criticism in the literature, the majority of GPs in this research suggested that if systematic changes were made to the website that ensured that OPF was true and valid, they would use OPF to improve their practice. Additionally, over a quarter of all patients believed that sharing their experience online on a doctor rating website would be taken more seriously by the GP or the GP practice. Similarly, GPs were also found to be concerned about the potential impact of OPF on their reputation. However, whether that drives improvement remains to be determined.

OPF as a source of patient empowerment – Altruism was found to be a perceived motivation for several patients to use OPF websites, and some patients suggested OPF could be used as a tool to place collective pressure on GPs, which could be perceived as advantageous. However, these patients were in very small numbers, and as outlined earlier, past patient usage and future consideration to use OPF websites was also found to be very low in this research. This contradicts the claim by the NHS and other feedback providers, as well as some academics that providing OPF websites would empower patients by giving them a 'voice' (Lagu et al. 2010). Nevertheless, it could be argued that OPF websites are a positive stepping stone towards patient empowerment in the NHS.

OPF as a measure of healthcare quality and a source for patient choice – Although this research did not set out to explore OPF websites for 'patient choice' or OPF as a measure of healthcare quality, the findings strongly challenge the popular notion that OPF is useful for patient choice, as advocated both by academics and the NHS (see section 3.3.9). The findings also appear to contradict Greaves et al.'s (2012b) observation of associations between NHS Choices general practice ratings and patient experience measures, strongly questioning the usefulness of OPF as a measure of quality in healthcare.

This is because current patient usage was found to be extremely scarce, and future intention to use OPF was also very low. Furthermore, around quarter of all patients

were more likely to leave negative feedback, and patients altered their preferred feedback method depending on whether they were going to leave positive or negative feedback about GPs. Altogether this provides evidence that OPF in England as it currently stands is not representative of the patient experience at large and is biased towards negative episodes, suggesting that the use of OPF for patient choice or as a measure of healthcare quality could be potentially dangerous and misleading. Currently the NHS Choices website is provided in England as the main source for patient choice, and the recommendation from this research is that this is reviewed by the NHS and policy makers. As detailed in Table 9-2, one suggestion to rectify this would be to include feedback collected from other sources on the NHS Choices website.

Summary of key recommendations – Detailed lists of recommendations are provided in section 9.4. In summary:

- OPF website owners must implement systematic changes to OPF websites (see Table 9-2) to address GPs' concerns, in order to convince them to use OPF for improvement, and promote such websites to their patients.
- There is a need for more promotion of OPF websites amongst both patients and GPs (see Table 9-3) and patients need convincing that OPF websites will be valued by GPs.
- OPF website providers should provide alternative non-digital methods to place feedback on OPF websites (see Table 9-4).
- The NHS/GP Practices should provide patients with feedback methods that are private and will directly reach the GP (see Table 9-5).
- The patient choice section of OPF websites where patients choose a healthcare provider must contain patient feedback from other sources, as well as other metrics, such as the clinical competency of the GP or CQC reports, and these must be combined with the overall 'star rating' that is displayed for each GP practice (see Table 9-2).

Main contributions of the research

This is the first piece of research that has explored healthcare professionals' and patients' attitudes towards OPF websites; and also the first that has explored patients' awareness and usage of OPF websites within the context of other feedback

mechanisms available in general practice. Furthermore, Study C was a nationally representative study, and it is the largest and most robust study conducted with patients about OPF to date. This work has therefore generated new data that determines GPs' and patients' awareness, usage and attitudes towards online patient feedback in England; and the findings from this research contribute to literature and practice by providing evidence both in favour of and against OPF (see section 9.2).

Given the popularity, acceptance and usage of consumer rating websites such as Trip Advisor, coupled with the increasing emphasis on PPI and patient experience in the NHS, and the millions of pounds investment into OPF websites by the NHS, the findings of this thesis were unexpected, and rather surprising. The evidence from this research illustrates that despite the NHS Choices website being live since 2007 (NHS Choices 2010), both patients and GPs require not only more awareness of OPF websites, but need to be actively convinced of the value and benefit of giving and receiving OPF. The evidence questions whether OPF websites are really needed or wanted by the majority of patients or GPs as a channel for experiential feedback in general practice in England, because very few patients would consider using OPF websites in the future, and the majority of patients prefer to leave experiential feedback directly with GPs or the GP practice or manager. This is surprisingly not due to privacy concerns or security concerns about OPF websites, nor is it due to any socio-health demographic factor; rather what patients appear to value the most about a method of feedback is a) ease and convenience of use b) the method being a direct method of giving feedback to the healthcare provider so that it reaches the provider and is used for improvement; and c) it is a private method. Furthermore, unlike previous academic work, the findings strongly challenge the validity of OPF as a source of patient choice and measure of quality (although this was not what this research had set out to explore).

However, the findings do suggest that OPF could be used to bring improvement in general practice by collecting patient feedback from a very small number of patients who may not give feedback through other channels, and OPF websites also fulfil a 'feedback gap' for a very small minority of patients. Although GPs were found to be highly critical of OPF websites (as the websites currently stand), if systematic changes were made to the website (such as verifying the identity of the patient for example),

the majority of them would be willing to use OPF for improvement and promote OPF websites to their patients.

The question could therefore be raised as to whether it is worthwhile for the NHS and other healthcare providers to invest in OPF websites for collecting patient experiential feedback in general practice, given that a) OPF websites currently only appeal to a very small minority of patients, b) GPs are currently not using OPF for improvement, and c) OPF websites as they are currently designed are not a valid source for patient choice. However, the recommendations provided in section 9.4 will help remedy this.

It could be argued that the provision of OPF websites, despite the problems identified in this research, is a move in the right direction, hinting towards a cultural and organisational shift within the NHS where patient experiences are valued by providing a mechanism for those experiences to be transparent and narrated in the public domain. However, based on the findings from this research, it may be more prudent for the NHS to channel its precious investment and resources towards more direct and private feedback methods in general practice (such as opportunities for face-to-face feedback, email-based feedback and web-based private feedback forms), as these are much more likely to be used currently by the majority of patients in England.

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APPENDICES

APPENDIX A – HISTORY OF PATIENT AND PUBLIC INVOLVEMENT (PPI) POLICY IN THE NHS

In 1948, when the NHS was formed under a Labour government, it was paternalistic in its approach to the care of patients, and the first serious attempt to involve patients and the public occurred in 1974 with the creation of Community Health Councils (CHCs). These councils were created to inform and help the public, and represented patients that had complaints; however they had very little influence over health policy and provision (Baggott 2005; Coulter 2011; Forster and Gabe 2008). Patient participation groups (further information about them in section 2.4.1) were also created in some general practices also in the 1970s, but they were limited in encouraging patient engagement (Brown 1999).

However, by the late 1980s, there was an increase in health consumer groups and patient organisations that campaigned for patients' rights and improvements in health services. The new Conservative government (from 1979-1997) was under pressure, and with changes to the way healthcare was provided, it did provide some opportunities for PPI through the CHCs (Baggott 2005), especially to illustrate public support for specific policies, such as the drive towards consumerism, where an 'internal market' for health was created, and GPs acted as proxy consumers and purchased services from secondary care on their patient's behalf (Forster and Gabe 2008). In 1991, the *Patient Charter* was introduced, whose aim was to make healthcare provision more responsive to patients' needs. The charter included the right to information about quality standards, however, research suggested that the charter was led by managerial requirements, and there was very little user involvement in its creation (Calnan and Gabe 2001; Coleman and Glendinning 2004).

In 1992, a 'local voices' initiative was introduced in relation to the internal market project, which unlike previous conservative policy focus on individual consumer, it had a collective focus (Forster and Gabe 2008). Citizen juries, focus groups and health panels were created to urge purchasers to consult their local communities about the allocation of resources and creation of new services (Coleman and Glendinning 2004; Pickard 1998). Although a progressive initiative, critics argued that the involvement was unrepresentative, limited, managerial led and public

involvement was only used to legitimise decision makers' own decisions (Coleman and Glendinning 2004; Harrison and Mort 1998).

In 1997, New Labour came into power, and under Blair's leadership, major strides were made towards public participation in all public services to democratise decision making, tackle social exclusion and include the disadvantage in decision making (Baggott 2005). In healthcare, Labour pledged to move away from the consumer model developed by the Conservatives to one of partnership, and placed particular emphasis on public involvement in primary care (Forster and Gabe 2008), by focusing on patient and user satisfaction surveys (Baggott 2005), and making them mandatory for hospital inpatients (Coulter et al. 2014). These ideas led to the development of the policy *Patient and Public Involvement* in 1999, which emphasised that regular PPI (from all groups including those socially disadvantaged and minorities) must be integrated into all NHS organisations, moving beyond individual care to strategic and operational matters. PPI was included in policy making at the Department of health, and lay members were also added to the newly developed organisations to enhance governance, such as the National Institute for Clinical Excellence (NICE) (Baggott 2005; Forster and Gabe 2008).

In late 1999, there was a crisis of public confidence in the NHS due to high-profile cases of serious NHS service failures (such as the Harold Shipman case), which meant that the New Labour PPI policy was revised again in the *NHS Plan* (2000). The emphasis was on patient-centred care, a better patient experience, and pressure was placed on all NHS organisations to include the public in service evaluation (Forster and Gabe 2008). Forster and Gabe (2008) suggest that the *NHS Plan* used four strategies including patient choice and the patient charter, to 'empower' patients, some of which were adopted more closely than others in the forthcoming years (further information about patient empowerment and the NHS plan is in section 2.5)

At a local collective level, Community Health Councils were abolished and PPI was established through the formation of Patient's forums in 2002, subsequently renamed as the patient and public involvement forums (PPIFs). The Primary Care Trust (PCT) PPIFs role was to monitor and review services, advise the trust, as well as collect and represent patient views and promote public involvement (Baggott 2005). The majority of the members had to be local residents. A new independent statutory patients' body to support the PPI forums was then established in 2003, the

Commission for Patient and Public Involvement in Health (CPPIH). It again reinforced the Labour government's commitment to PPI. However, the CPPIH faced immense difficulties, and it failed to build support or raise a public profile, and in 2004, and just after 18 months it was abolished (Butler and Greenhalgh 2011). PPI forums were also criticised for their "complexity and incoherence": there was confusion between its role and PALs; it was criticised for being too focused on healthcare alone; and it was under-funded (Baggott 2005). They were replaced in July 2006 by the Local Involvement Networks (LINks) (and in 2013 by Healthwatch).

After establishing collective involvement, New Labour shifted its efforts to individualistic approach; with a focus on expansion of 'choice' in the *NHS improvement plan 2004* (choice has been discussed in section 2.2). In 2009, the NHS constitution was published (NHS England 2009), which again re-iterated the right to patient choice, the right to be informed and have a say in one's healthcare, involvement in the planning of healthcare services, the right to complain, and be informed of the outcome, and encouraged patients to leave feedback – both positive and negative - to aid improvement. In April 2009, a new health and social care regulator was created, the Care Quality Commission (CQC), whose role was to regulate and inspect health and social care services in England (further details on CQC are in section 2.4.1).

By 2010, there was increasing interest in PPI at a government policy level, with a promise that it would increase quality and decrease cost (Butler and Greenhalgh 2011). However, a survey from Picker Institute claimed that with regard to public involvement in healthcare, England was behind Australia, Canada, New Zealand, Germany and the USA (Coulter 2006), and a survey from the Common wealth fund of New York also claimed that England was at the bottom of the list for patient centred care and patient engagement (Davis et al. 2010).

In May 2010, a new Conservative-led coalition government was elected, who also promised to focus on patient engagement. Their white paper *Equity and Excellence: Liberating the NHS's* mantra was to put the patient at the centre of any decision making: "no decision about me without me". The *Health and Social Care Bill 2010/11* gave GPs greater influence on commissioning (with the creation of GP-led Clinical Commissioning Groups (CCGs)), and abolished strategic health authorities (SHAs) and primary care trusts (PCTs), 'liberating' trusts from central control. It also set out

NHS commissioners duties with respect to patient and public participation, including making arrangements for patient participation in care and treatment, service redesign and publishing the feedback they receive from the local Healthwatch (NHS England 2013).

The coalition government's response to the Mid Staffordshire NHS Foundation Trust Public Inquiry in May 2013 (Department of Health 2013) reinforced putting patients first, and its commitment to fully involve the public in the NHS. It promised a system that was not only more responsive to patient, staff and public feedback, but one that would actively seek out feedback. It also laid the foundations for the Friends and Family Test (FFT) (further details on FFT are in section 2.4.1)

The NHS England's (2014a) Five Year Forward View report also promised patients greater control over their own care, with a promise to access their medical and care records, greater increase in choice over where and how they receive care and an increase in PPI across all sectors of healthcare. After the Conservative Party formed a majority government in May 2015, the NHS constitution was revised for the second time (Department of Health 2015c). However, there is little evidence as to whether the rights from the NHS constitution are being upheld (Redding 2013).

APPENDIX B – ETHICAL APPROVAL AND CONSENT FORM

(i) Ethical approvals

Ethical approvals for all of the studies were granted by the Biomedical & Scientific Research Ethics Committee at the University of Warwick, and for Study A from the NHS Cambridgeshire PCT too.

15 May 2012

Warwick Medical School

PRIVATE
Mrs Salma Patel
PhD student
International Digital Laboratory
WMG, University of Warwick
Coventry
CV4 7AL

Dear Salma

Study Title and BREC Reference: *GP's attitude towards online patient feedback 214-05-2012*

Thank you for submitting your revisions to the above-named project to the University of Warwick Biomedical Research Ethics Sub-Committee for Chair's Approval.

I am pleased to confirm that I am satisfied that you have met all of the conditions and your application meets the required standard, which means that full approval is granted and your study may commence.

I take this opportunity to wish you success with the study and to remind you any substantial amendments require approval from the committee before they can be made. Please keep a copy of the signed version of this letter with your study documentation. The committee also requires you to complete an End of Study Declaration Form when you reach the end of your study: this form has been e-mailed to you.

Yours sincerely,

Jane Barlow

Professor Jane Barlow
Chair
Biomedical Research
Ethics Sub-Committee

Copy:
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Professor Lucy Hooberman
Dr Rebecca Cain
Dr Kevin Neailey

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06th July 2012

Mrs Salma Patel
International Digital Laboratory
WMG, University of Warwick
Coventry
CV4 7AL

Dear Mrs Patel

Re: L01196 General Practitioners' attitudes towards online patient feedback (Study A and Study B)

Your proposal has been reviewed by NHS Cambridgeshire's Research Governance Panel in accordance with the Department of Health Research Governance Framework for Health and Social Care.

I am pleased to inform you that NHS Cambridgeshire has given permission for the following research to take place.

This permission is subject to the enclosed standard terms and conditions and conditional upon you notifying the research governance team of any changes to the study-related paperwork.

Unless we hear from you within a month of this letter, we will assume that you are abiding by these conditions.

The project must follow the agreed protocol and be conducted in accordance with Trust policy and procedures in particular in regard to data protection, health & safety and information governance standards. The research team are required to follow the reasonable instructions of the research site manager and can contact the RMG office for RMG advice or the Trust RMG lead in relation to queries on local policy.

On completion of clinical trials of interventional medicinal products/devices participants need to be aware that local Trust prescribing policy and formulary applies therefore participants cannot expect to continue on the research trial product/device on completion of the trial.

Approval is subject to adherence to the Data Protection Act 1998, NHS Confidentiality Code of Practice, the Human Tissue Act 2004, the NHS Research Governance Framework for Health and Social Care, (2nd edition) April 2005, the Mental Capacity Act and any further legislation released during the time of this study. Approval for Clinical Trials is on the basis that they are conducted in accordance with European Union Directive and the Medicines for Human Use (Clinical Trials) Regulations 2004 principles, guidelines and later revisions, and in accordance ICH Good Clinical Practice.

Members of the research team must where instructed have appropriate substantive or honorary research contracts or letters of access with the Trust prior to commencing work on the study, additional researchers who join the study must also hold a suitable contract or letter of access before they start.

You will be required to complete monitoring information during the course of the research, as requested by the RMG office. NHS Cambridgeshire reserves the right to withdraw research management approval for a project if researchers fail to respond to audit and monitoring requests.

Should any adverse incidents occur during the research, NHS Cambridgeshire's Incident and Near Miss Reporting Policy should be used, the RMG Office informed and incident procedures adhered to at the research site.

If you make any amendments to your project, please ensure that these are submitted to the research ethics committee and the RMG office and that any changes are not implemented until approval has been received.

We welcome feedback about your experience of this review process to help us improve our systems. May I take this opportunity to wish you well with your research and we look forward to hearing the progress and outcomes for the study.

Please contact the RMG team should you have any queries.

Yours sincerely,

Christine A Macleod

Dr Christine Macleod
Cluster Medical Director
NHS Cambridgeshire and NHS Peterborough

Dr Peter Hedges

6th May 2015

Warwick
Medical School

PRIVATE
Mrs Salma Patel
[redacted]

Dear Mrs Patel,

Study Title and BSREC Reference: *Public preference and motivation for using online patient feedback* REGO-2015-1472

Thank you for submitting the above-named project to the University of Warwick Biomedical and Scientific Research Ethics Committee for research ethical review.

I am pleased to advise that research ethical approval is granted.

May I take this opportunity to wish you success with the study, and to remind you that any substantial amendments require approval from BSREC before they can be implemented. Please keep a copy of the original signed version of this letter with your study documentation.

Yours sincerely

P.P. Graham Hewitt

Professor Scott Weich
Chair
Biomedical and Scientific
Research Ethics Sub-Committee

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THE UNIVERSITY OF
WARWICK

WARWICK
MEDICAL SCHOOL

PRIVATE
Mrs Salma Patel
[redacted]

14th December 2015

Dear Mrs Patel,

Study Title and BSREC Reference: *Public preference and motivation for using online patient feedback* REGO-2015-1472 AM01

Thank you for submitting a substantial amendment application for the above-named project to the University of Warwick's Biomedical and Scientific Research Ethics Sub-Committee.

I am pleased to confirm that the changes that you wish to make to this study have been approved.

Please keep a copy of the signed version of this letter with your study documentation.

Yours sincerely

P.P. Graham Hewitt

Professor Scott Weich
Chair
Biomedical and Scientific
Research Ethics Sub-Committee

Biomedical and Scientific Research Ethics Sub-Committee
A010 Medical School Building
Warwick Medical School,
Coventry, CV4 7AL.
T: 02476-528207
E: BSREC@Warwick.ac.uk

http://www2.warwick.ac.uk/services/ris/research_integrity/researchethicscommittees/biomed

(ii) Consent form (used across all studies)

The consent forms used were developed following the guidance suggested by the ethics committee at the University of Warwick. An example of one of the consent forms used in this research is provided below.

Participant Consent Form

Name of study: Public preference and motivation for using online patient feedback

Study Part: A (Interview) **Name of Researcher: Salma Patel**

Please initial the boxes you agree with

The first five are necessary to participate, the final one is optional.

1. I confirm that I have read and understand the attached information sheet for the project named above. I have had the opportunity to consider the information and ask questions, and have had these answered satisfactorily. ☐
2. I understand that my participation in this research is voluntary and that I am free to withdraw at any time without giving any reason, without my legal or employment rights being affected. ☐
3. I agree to participate in this research study. ☐
4. I agree to the interview being recorded and transcribed to aid the academic researchers' analysis. ☐

Post-study:

5. I agree to quotes from the interviews being used anonymously in the dissemination of the work – in written form (e.g. papers, thesis) as well other forms (e.g. in presentations at conferences). ☐
6. I agree to audio recordings from the interviews being used in the dissemination of the work – both internally in the department and externally (e.g. at conferences or online), and I understand these will be shared with me before being publicized. ☐

Name of participant	Signature	Date
Name of researcher	Signature	Date

One copy will be kept by the researcher and one by the participant.

APPENDIX C – ADDITIONAL MATERIAL FOR STUDY A (PHASE 1)

Appendix C consists of i) the topic guide used during the interviews, ii) vignettes used during the interviews, iii) invitation letter, iv) information sheet, v) thematic framework created in NVivo, and vi) the classification sheet from NVivo.

i) Topic guide (Study A)

Topic Guide

Interview: GPs' attitudes towards online patient feedback

1. Introduction
Introduction to research: nature and purpose, confidentiality and permission (consent form signed) – Put recorder on now.

2. Generic Participant background
Name/sex/age/professional role of participant/years of practising

3. Internet Use
Use and frequency of: Internet/social media/rating websites such as tripadvisor & amazon/for decision making and rating/smartphone/apps

4. Generic patient feedback tools: experience & attitudes towards them

- **Current methods** used in the surgery to collect patient feedback – do they collect valuable data? If they don't collect useful data, why don't they? Which tools give data that can lead to improvement of their own practice?
- **Significance** of patient feedback – Do you think it is important to collect patient feedback? How important is it to use patient feedback? What could it be used for?
- **Encouraging patients to give feedback** – Do you think the NHS should encourage patients to give feedback on the care they've received? Do you ever encourage patients to give you feedback?
- **Receiving positive/negative feedback** – how does that make you feel?
- **Response to generic patient feedback** – Have you ever responded to patient feedback? If so, how and why?
- **Use of generic patient feedback** – Have you ever used the data? If so how?
    - Can the data be used for professional development? How and why?
    - Have you informed patients of your use of their feedback? How and why?
- **Real-time feedback** - Real-time feedback is when patients give feedback as soon as they've seen you. Would you encourage your practice to implement a real-time feedback tool?

5. Online feedback: experience & attitudes towards them

- **Experience of online feedback:** Do you know what online patient feedback is? *(If not, researcher will explain briefly)*
    - **As a patient:** Have you ever given/used online patient feedback? Would you consider using online patient feedback to make a choice of service provider or clinician? Do you think it's a useful way to decide which service provider or clinician to choose?
    - **As a professional:** Are you aware if you've received online patient feedback? If so, what did you do with it? Did you use it, and how? If ignored, why?
- Impact of online patient feedback on GP
    - Would you prefer to receive a **formal complaint about you offline** rather than online feedback? Why?
    - Do you think there's a difference between negative feedback and complaints?

Page 1 of 3

- Does the practice have a different procedure for complaints & feedback?

- How does receiving **positive patient feedback in public** make you feel? (May use vignette 2 to demonstrate what positive feedback is)
- How does receiving **negative patient feedback in public** make you feel? (May use Vignette 1 to demonstrate what negative feedback is)
- Do you think patients have a **right to give you feedback** on your performance as a GP? Do you think they have a right to place it online?
- Some patients may argue that they have a **right to know** if providers are sub-standard. How do you feel about that?
- **Some patients may say** that doctors should be positive about receiving feedback to identify opportunities for improvement. How do you feel about that?

- **Perceived concerns: Do you have any concerns about online patient feedback?**
  Possible prompts:

  - Does the **transparent and public nature** of the feedback targeted towards you or the practice concern you or worry you? Why?
  - Do you think your patients would rate you not only based on your professional skills but also as a **person**? (Does this worry you? Why?)
  - Do you think a **negative review** read by a patient of yours may prevent a previously good doctor-patient relationship from continuing with the same ease? Why?

- **Perceived benefits: Can you see any benefits in relation to online patient feedback vs other feedback methods?**
  Possible prompts:

  - Patients argue that that they give feedback because they have a desire to assist in **improving the service.** Do you think this is true? Why?
  - Do you think anonymous feedback that is online may provide new insights on the perceptions and needs of your patients. Why?
  - Some argue online patient feedback will force doctors to improve their performance and bedside manner out of **fear that patients may post online about them.** Do you think it will 'force' GPs to improve performance? Why?
  - Do you think your patients would have **more confidence** in you if they read positive reviews of yours online? Why?
  - Some argue that openness leads to **increased trust** between doctors and those they care for, and a relentless increase in quality health outcomes. What do you think about that?
  - Do you think patients are less likely to send an official complaint about you if they are encouraged to give anonymous feedback online?
  - Do you think your patients would find it easier to give anonymous feedback online than paper based anonymous feedback?

6. Using online feedback

Response

- Should a GP respond to critical feedback? (may use vignette 1 to demonstrate)
- Should a GP respond to positive feedback? (may use vignette 2 to demonstrate)
- In which situations would you consider responding to online feedback?
- Do patients have a right to receive a response to the feedback they leave? Why?

Use

- Have you ever used online feedback? How?

- Would you use online feedback to change your practice? If not, why not? If yes, how and why?
- Currently reviews are anonymous on NHS Choices. Would there be more useful to you if they weren't? Why?

7. Feedback to practice vs. feedback to GP

- Currently there are two major websites in the UK where patients can give feedback to the GP. One website is where they give feedback and it is left under the practice name, and the second is where they leave feedback under a particular named GP. Which do you prefer/feel more comfortable with?
- Some argue that to support continuous self-improvement requires individual data, not an average score or feedback for the whole department or practice. Would you agree? Why? Which one would you feel more comfortable with? Why?
- (Possible question: A GP may be getting a low score due to something not related to him, for example hypothetically the patient may be annoyed about the time allocation. *(Possibly show Vignette 3 as this point).* Would this have an effect on whether you would prefer to receive personal feedback instead of practice based feedback?)

8. Future of online feedback

- What are your thoughts on the idea that the collective voice of healthcare users, not the powers of the traditional healthcare regulators, becomes the new health watchdogs?
- Online feedback stories vs. surveys – Do you think stories that narrate the patient experience are more likely to lead to changes in your behaviour or practice than say the results of a survey?
- Would you ever encourage your patients to give online feedback? Why?
- Do you think if you or your surgery encouraged patients to give online feedback you would be looked upon more favourably? Why?
- Do you think this service (the NHS Choices service) should remain or should be scrapped, or should change in any way? If so why?
- Do you think the iwantgreatcare website should remain or should be scrapped, or should change in any way? If so why?
- Where do you see the future of online patient feedback?

9. Social Media and Feedback

- Does your practice have a social media presence? If so, what does it use it for?
- How do you feel about feedback left on Facebook page or on twitter? Any plans to respond to it?
- Would you ever ask for feedback using social media? Why?
- Do you think if you or your surgery engaged with patients using social media you would be looked upon more favourably? Would it benefit you/patients? How? Why?
- Do you think if you or your surgery encouraged patients to give feedback using social media you would be looked upon more favourably? Would it benefit you/patients?
- Do you think there is a difference between leaving feedback on NHS Choices for example and leaving feedback on social media?

I've had difficulty recruiting GPs to take part in this study, and I'm really grateful you agreed to take part. May I ask what motivated you to take part in this research?

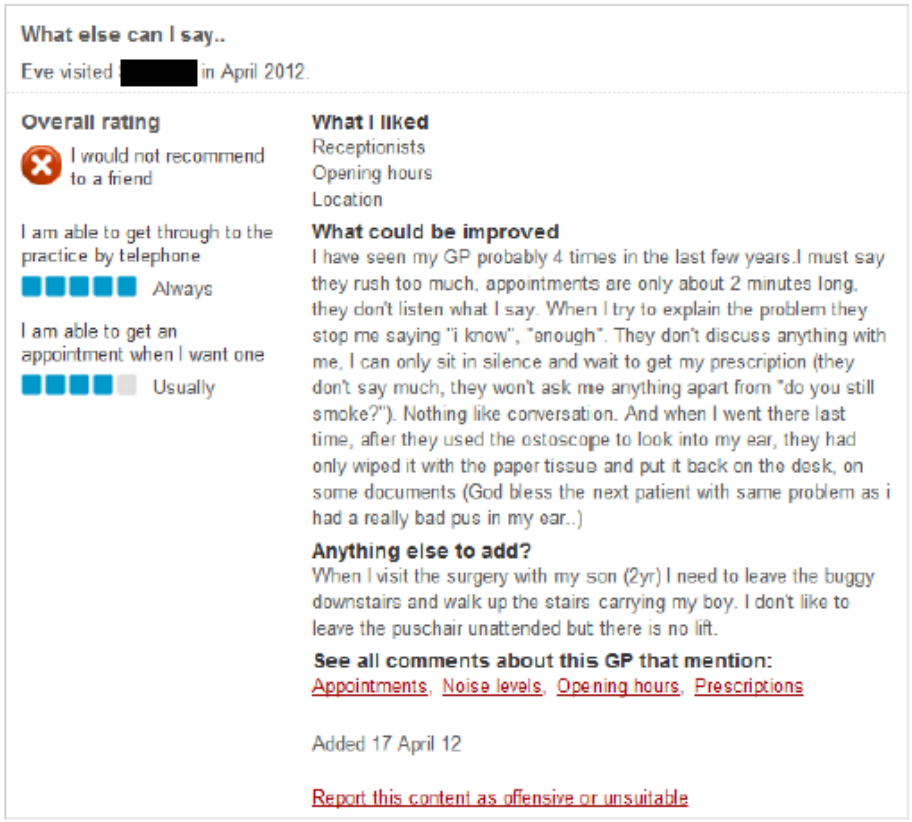
10. Ending –

- Any further things you'd like to add
- Thank you
- Inform them of payment and leave business card.

ii) Vignettes (Study A)

The following three vignettes were used during the interviews with GPs.

Vignette 1
Study A
An example[1] of feedback left on NHS Choices



What else can I say..

Eve visited [redacted] in April 2012.

Overall rating

I would not recommend to a friend

I am able to get through to the practice by telephone

Always

I am able to get an appointment when I want one

Usually

What I liked

Receptionists
Opening hours
Location

What could be improved

I have seen my GP probably 4 times in the last few years.I must say they rush too much, appointments are only about 2 minutes long, they don't listen what I say. When I try to explain the problem they stop me saying "i know", "enough". They don't discuss anything with me, I can only sit in silence and wait to get my prescription (they don't say much, they won't ask me anything apart from "do you still smoke?"). Nothing like conversation. And when I went there last time, after they used the ostoscope to look into my ear, they had only wiped it with the paper tissue and put it back on the desk, on some documents (God bless the next patient with same problem as i had a really bad pus in my ear..)

Anything else to add?

When I visit the surgery with my son (2yr) I need to leave the buggy downstairs and walk up the stairs carrying my boy. I don't like to leave the puschair unattended but there is no lift.

See all comments about this GP that mention:

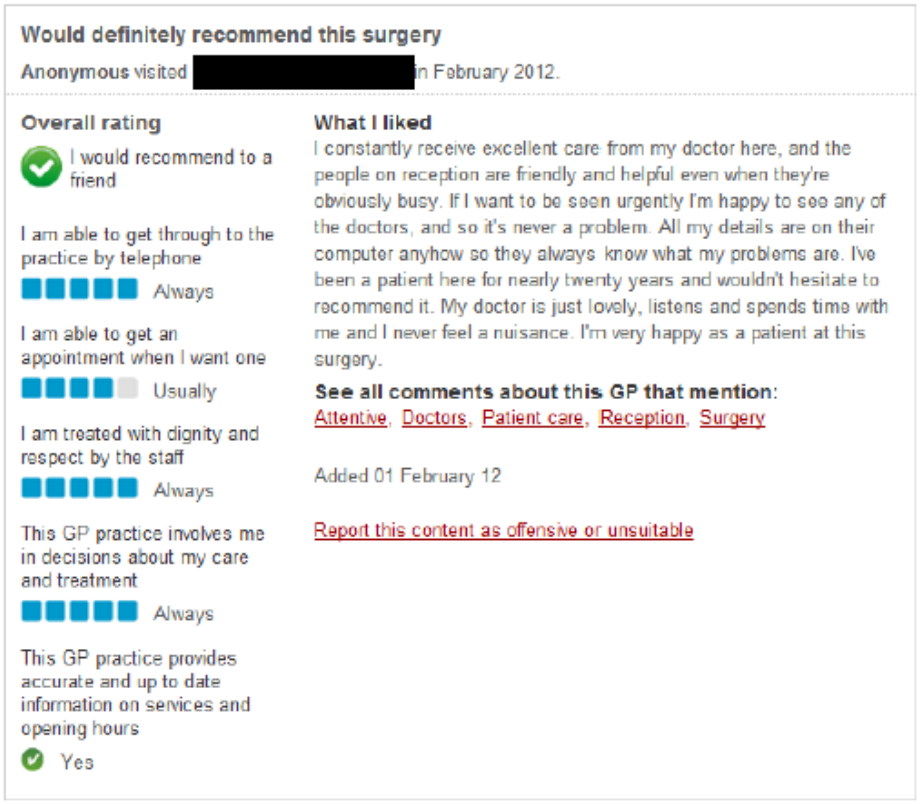
Appointments, Noise levels, Opening hours, Prescriptions

Added 17 April 12

Report this content as offensive or unsuitable

[1] This piece of feedback was left for a GP surgery on the NHS Choices website. This was randomly selected as a negative type of patient feedback from the ones scrolling on the front page of NHS Choices.

Vignette 2
Study A
An example[2] of feedback left on NHS Choices



Would definitely recommend this surgery

Anonymous visited [redacted] in February 2012.

Overall rating

I would recommend to a friend

I am able to get through to the practice by telephone

Always

I am able to get an appointment when I want one

Usually

I am treated with dignity and respect by the staff

Always

This GP practice involves me in decisions about my care and treatment

Always

This GP practice provides accurate and up to date information on services and opening hours

Yes

What I liked

I constantly receive excellent care from my doctor here, and the people on reception are friendly and helpful even when they're obviously busy. If I want to be seen urgently I'm happy to see any of the doctors, and so it's never a problem. All my details are on their computer anyhow so they always know what my problems are. I've been a patient here for nearly twenty years and wouldn't hesitate to recommend it. My doctor is just lovely, listens and spends time with me and I never feel a nuisance. I'm very happy as a patient at this surgery.

See all comments about this GP that mention:
Attentive, Doctors, Patient care, Reception, Surgery

Added 01 February 12

Report this content as offensive or unsuitable

[2] This piece of feedback was left for a GP surgery on the NHS Choices website. This was randomly selected as a positive type of patient feedback from the ones scrolling on the front page of NHS Choices.

Vignette 3
Study A
An example[3] of feedback left on iwantgreatcare.org

Report this review

Added by a patient 3 months ago (27 January, 2012)

Listening 90%
Recommend 90%
Trust 90%

Their thoughts on this service

I first saw Dr [redacted] a few months after I was diagnosed with type 2 diabetes. At the time I had been diagnosed tablets and was taking them, but before seeing Dr [redacted] I felt I had not been given enough information about my condition. On explaining this to Dr [redacted] he directed me to various websites and ensured that I went on a course run by the local health authority. This did help as it answered all of my questions and the group were able to share their experiences. Each time I have visited Dr [redacted] I feel he has listened to any concerns I have and has done his best to ensure I am on the medication that suits me.
My only slight grumble is that I have sometimes had to wait up to 40 mins after the time of my appointment to see Dr [redacted], but this may be more due to the amount of time allowed per patient than due to Dr [redacted]s time management who is obviously aware of the over-run and apologises if it happens. This does seem to have improved lately and on my last visit in January 2012 I was seen 5 mins after my appointment time.

[3] This piece of feedback was left for a GP on the iwantgreacare.org website. This was randomly selected as patient feedback that is both negative and positive.

iii) Invitation letter (Study A)

[Date]

[Full Name]
[Practice name]
[Address 1]
[Address 2]
[Postcode]

Dear Dr [name],

Research on GPs' attitudes towards online patient feedback

We are undertaking an independent study exploring GPs' attitudes towards online patient feedback. As a GP, we would be very interested to hear about your experiences of using online patient feedback, and to learn more about your general perception and attitude towards online patient feedback and to patient feedback in general.

Your participation would involve setting aside around one hour to take part in an interview at your work place. **Your practice will be paid £80 for you to take part in this study.** The study has research governance approval from NHS Cambridgeshire and the Biomedical Research Ethics Committee at the University of Warwick. The enclosed information sheet and consent form set out the study in more detail.

If you would be happy to participate in this study, please fill in the attached form and return it in the stamped addressed envelope. Following receipt of your completed form, we will be in touch to arrange a convenient day and time to come and interview you.

If you would like any further information, please contact the Chief Investigator Salma Patel by telephone on 07796 141550 or by email at: salma.patel@warwick.ac.uk.

Thank you for your time and we look forward to hearing from you soon.

Yours sincerely,

Salma Patel, Dr Rebecca Cain, Dr Kevin Neailey and Professor Lucy Hooberman

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Web: www.wmg.warwick.ac.uk

iv) Information sheet (Study A)

Information Sheet for Participants

Interview: GPs' attitudes towards online patient feedback

You are invited to participate in this research. Before you decide whether or not to participate it is important for you to understand why the research is being done and what participating will involve. Please take your time to read the following information carefully and ask if anything is unclear.

What is the purpose of this interview?
This interview is the first part of a research project that aims to explore GPs' attitudes and perceptions towards online patient feedback and to patient feedback in general. Online patient feedback can be defined as feedback left by patients, carers or service users on public web-based platforms such as NHS Choices, Patient Opinion and iwantgreatcare.org; and on applications such as the iPhone based *Great Care* app.

Why have I been invited?
You have been randomly selected from a list of GPs in Cambridgeshire.

Do I have to take part?
No. It is up to you to decide whether or not to participate and you are free to stop your involvement at any time without giving a reason. Your decision will not impact in any way on your legal or employment rights.

What would be involved?
After you have returned the 'acceptance to participate' form, the researcher will call you to arrange a day and time that is the most convenient for you to take part in an interview.

The researcher will travel to your workplace. You will be given the opportunity to ask any questions regarding the interview, and you will be asked to complete a consent form prior to the interview starting.

The interview will take between 45 minutes to an hour, depending on the depth of the discussions.

The discussion between you and the researcher in the interview will be audio recorded for transcription and analysis. If you give permission, the interview will be video recorded too.

Will my information be kept confidential?
The information you provide to us will be kept confidential, and personal data will be anonymised at transcription. Only members of the research team will have access to your responses. Audio files will be transcribed without making a note of your name. Under no circumstances would identifiable responses be provided to the NHS or any third parties. All data collected will be destroyed at the end of three years.

If you agree for the audio or video of your interview being used for dissemination of the research (this is completely optional), it may be placed online or used at conferences to disseminate the research.

All data collection, storage and processing will comply with the principles of the Data Protection Act 1998 and the EU Data Protection Directive 95/46/EC.

What happens at the end of the study?
Study results may be submitted for publication in academic and professional journals, conference proceedings, books, online publications, and used in presentations at conferences and workshops. The results will also be included in the doctoral thesis of Salma Patel.

Will I be reimbursed?
To cover the cost of locum reimbursement for your time we will make a payment of £80 to you for your participation.

Who is funding and conducting the research?
The research is being conducted by Salma Patel, a doctoral researcher at the University of Warwick.

It is funded by the Engineering and Physical Sciences Research Council (EPSRC) and is part of the Participation in Healthcare Environment Engineering (PHEE) programme. Further information can be found here: http://tinyurl.com/pheeproject

Who has reviewed the research?
The research has been reviewed and given a favourable opinion by the Biomedical Research Ethics Committee at the University of Warwick as well as the NHS Cambridgeshire PCT.

If I wish to discuss the study further who should I contact?
Please contact Salma Patel.

Email: salma.patel@warwick.ac.uk **Phone:** 07796 141550

University Address: International Digital Laboratory, WMG, University of Warwick, Coventry, CV4 7AL.

Who would I contact to complain about this research?
If you are not happy with the way in which this research has been conducted, you should contact the University of Warwick's Deputy Registrar, Nicola Owen (details below).

Email: DeputyRegistrar@warwick.ac.uk **Phone:** 02476 523713

Address: University of Warwick, Gibbet Hill, Coventry, CV4 7AL.

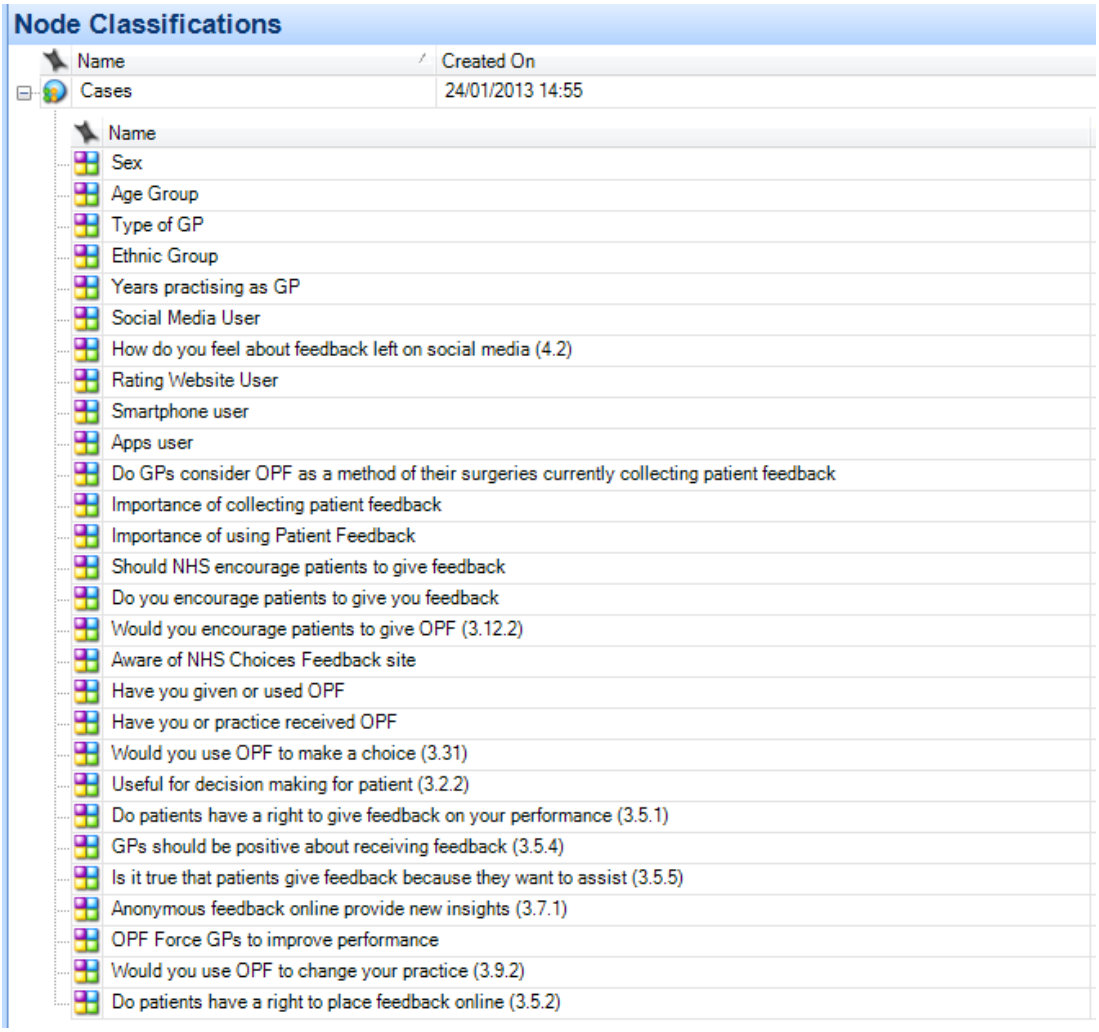
v) Thematic framework (Study A)

The thematic framework created in NVivo at the analysis stage is shown below.

Name	Sources	References
1. Attitude towards rating websites like Trip Advisor or Amazon Reviews	20	20
2. Generic patient feedback tools, experience & attitudes towards them	N/A	N/A
2.1 Methods used in surgery to collect patient feedback	20	21
2.1.1 Methods that give valuable data	15	18
2.2 Significance of patient feedback	0	0
2.2.1 Do you think it is important to collect patient feedback	20	21
2.2.2 How important is it to use patient feedback	19	19
2.3 Encouraging patients to give feedback	N/A	N/A
2.3.1 Should NHS encourage patients to give feedback	17	17
2.3.2 Do you encourage patients to give you feedback	18	19
2.4 Receiving positive or negative generic feedback	0	0
2.4.1 Receiving positive feedback	20	20
2.4.2 Receiving negative feedback	20	20
2.5 Response to generic patient feedback	19	21
2.6 Use of generic patient feedback	N/A	N/A
2.6.1 Have you ever used the data, If so how,	19	25
2.6.2 Informing patients if you've used their feedback	17	20
2.7 Real time feedback	20	20
2.8 Stories vs surveys, leading to change in practice	20	21
3. Online feedback, experience & attitudes towards them	N/A	N/A
3.01 Personal experience of Online Patient Feedback	N/A	N/A
3.1.1 Awareness of online patient feedback	20	21
3.1.2 As a patient, have you ever given or used online patient feedback	19	20
3.1.3 As a professional, are you aware if you've recieved online patient feedback	20	25
3.02 OPF for Choice	N/A	N/A
3.2.1 Would you consider using online patient feedback to make a choice	15	15
3.2.2 Is it a useful way to decide which service provider	20	21
3.03 Complaint vs negative feedback	N/A	N/A
3.3.1 Preference, Complaints vs negative OPF	20	23
3.3.2 Is there difference between negative feedback & complaint	18	19
3.3.3 Does practice have different procedure for complaints & feedback	8	9
3.04 Receiving negative or positive OPF	N/A	N/A
3.4.1 Positive OPF	20	20
3.4.2 Negative OPF	20	25
3.05 Attitude towards patient feedback & OPF	N/A	N/A
3.5.1 Do patients have a right to give feedback on your performance	19	19
3.5.2 Do patients have a right to place feedback online	18	18
3.5.3 Patients argue they have right to know if providers are substandard	18	20
3.5.4 Drs should be positive about receiving feedback	19	19
3.5.5 Patients say they give feedback because they want to assist - true	17	19
3.5.6 Openness leads to increase trust & quality health outcomes	9	9
3.06 Perceived concerns & limitations of OPF	19	44
3.6.1 Does transparent & public nature of feedback worry you	19	20
3.6.2 Patients rating you as a person - does it worry you	10	11
3.6.3 Negative review affect dr-patient relationship	18	19
3.07 Perceived benefits of OPF	19	23
3.7.1 Anonymous feedback online provide new insights	20	20
3.7.2 OPF will force GPs to improve performance	20	22
3.7.3 Patients have more confidence if they read positive reviews	19	22
3.7.4 Patients less likely to send complaint if encouraged to give OPF	18	18
3.7.5 Patients find it easier to give online feedback	19	19
3.08 Responding to OPF	N/A	N/A
3.8.1 Should GPs respond to negative OPF	20	25
3.8.2 Should GPs respond to positive OPF	20	20
3.8.3 Any situations where you'd consider responding to OPF	15	15
3.8.4 Patients have right to receive a response to OPF	9	10
3.8.5 Can GPs respond to OPF	8	8
3.09 Using OPF	N/A	N/A
3.9.1 Have you ever used OPF	3	6
3.9.2 Would you use OPF to change your practice	16	17
3.10 Anonymity of OPF - useful or not useful	20	22
3.11 Feedback to practice vs. feedback to GP	N/A	N/A
3.11.1 Practice based or GP based OPF - which prefer	20	24
3.11.2 To support continuous self-improvement requires individual data	14	19
3.12 Future of online feedback	N/A	N/A
3.12.1 Collective voice of healthcare users becomes health watchdog	19	20
3.12.2 Would you encourage patients to give OPF	20	24
3.12.3 If you or surgery encouraged OPF, looked upon more favourably	19	20
3.12.4 Should NHS Choices be changed, scrapped, remain	20	21
3.12.5 Should iwantgreatcare be changed, scrapped, remain	13	17
3.12.6 Where do you see the future of OPF	16	23
3.12.7 Suggestions to improve OPF	5	9
3.13 Misunderstandings about OPF	7	11
4. Social Media and Feedback	N/A	N/A
4.1 Does practice have SM presence	20	20
4.2 How do you feel about feedback left on SM	20	22
4.3 Would you ever ask for feedback on SM	16	16
4.4 Engaging with patients using SM, looked upon more favourably	20	21
4.5 Encouraging feedback on SM, looked upon more favourably	20	22
4.6 Difference between feedback on SM & NHS Choices	16	17
4.7 General attitudes towards Social Media	14	18
5. Difficulties recruiting GPs	16	16

vi) Classification sheet (Study A)

A copy of the classifications used in the analysis stage to compare and contrast results from different nodes and themes.



APPENDIX D – ADDITIONAL MATERIAL FOR STUDY B (PHASE 2)

Appendix D consists of i) the topic guide used during the interviews, ii) interview materials, iii) invitation letter, iv) information sheet, v) the recruitment poster.

i) Topic guide (Study B)

Topic Guide

Interview: Public preference and motivation for giving online patient feedback

1. Introduction

Introduction to research: nature and purpose of research, confidentiality and permission (consent). (Interview length: approximately 45 minutes.)

2. Explain terms used in the interview

- Feedback – relates to review, ratings and complaints that you may give or have given to your GP
- Feedback about your GP – it means in relation to the experience of a consultation that you have had with your GP
- Explain that the questions relate to both positive and negative feedback.

3. GP use

- Roughly, how many times have you had a consultation/appointment with a GP in the past year?

4. Main questions

Awareness of option to give feedback about GP

Are you aware that you can give feedback about your experience of a consultation/appointment with a GP? What methods are you aware of? (If online mentioned, can you name any of the websites?)

Explain the two terms: *Paper-based feedback and online feedback here using vignettes 1 & 2 where appropriate.*

History of 'feedback about GP' – if any

Have you ever given feedback about your GP? (both online and offline)

If no, why not? If yes:

a. How many times roughly have you given feedback about your GP?
b. How did you give the feedback and to whom? (If only one method used)
c. Why did you use this particular method to give feedback?
d. Was the feedback positive or negative?
e. Did you receive a response to the feedback?
f. Were you satisfied with the response?

Paper-based and online feedback

- Would you consider leaving feedback about your GP using paper-based methods? If yes, why? If not, why not?
- If yes, is this the same for both negative and positive feedback?
- Would you consider leaving feedback about your GP online? If yes, is this the same for both negative and positive feedback?

Perceived motives/non-motives for leaving feedback about your GP

- What would be your reasons, if any, for leaving feedback about your GP using paper-based methods? Would these be the same reasons for leaving feedback online?
- What would be your reasons, if any, for not leaving feedback about your GP using paper-based methods? Would these be the same reasons for leaving feedback online?

Perceived motivations for leaving feedback about your GP

- What type of experience, if any, would motivate you to leave paper based feedback about your GP offline? Is this the same for online feedback?
- When are you more likely to leave feedback using paper-based methods: when you've had a negative experience or a positive experience? Is this the same for online feedback?
- Are you more likely to leave paper-based feedback when you've had an extreme experience? Is this the same for online feedback?

Perceived risks of offline feedback, if any

- Do you believe there may be risks to you in leaving feedback online about your GP? If yes, what are they and why? If no, why not? Would the same risks/non-risk apply for leaving feedback through paper-based methods?

Anonymity when leaving feedback

- Would you be happy to leave your real name when you leave feedback about your GP online? If yes, why? If not, why not? Is this same for leaving your name on a paper-based card?

Relationship with GP

- Do you think your relationship with your GP will change if you leave your name on a piece of paper-based feedback you have left for him/her? If yes, how? If no, why not? Is this the same for leaving it online?

Naming GP

- Would you like to name your GP when leaving feedback about him/her online? If yes, why? If no, why not? Is this the same for when you leave feedback through paper-based methods?
- If you had to leave negative feedback online, do you think it is fair to 'name and shame' your GP online? Do you think anything would happen as a result of naming your GP online?
- Do you think it is fair for GPs to ask you not to mention them by their name when you leave feedback about them online? If yes, why? If not, why not?

Content of online feedback for GP

- Imagine you had to leave feedback through a paper-based method. Would you prefer to leave it by (four options):
    1. answering closed ended questions like ticking boxes yes/no
    2. writing sentences about your experience
    3. mixture of both
    4. Or something else? If so, what?

  Would this be the same for leaving feedback online?

- Would you consider leaving information about your diagnosis for example in the feedback that you may leave online? *(personal information)* How about on paper?

Expectation of GP response/action to feedback

- Do you think your GP will welcome any feedback you leave for him/her? If yes, why? If no, why not? Would this be the same for both paper-based and online?
- If you left feedback about your GP online, do you expect your GP to do anything with that feedback? What do you expect them to do? Is this the same as when you leave feedback on paper?
- *Do you expect your GP to respond to any feedback you leave using online methods? If yes, why? If no, why not? Is this the same for paper-based methods?*
- Do you think your GP, if needed, will make any changes based on any feedback you leave for him/her using paper-based methods? If yes, why? If no, why not? Is this the same for feedback you leave online?
- If you felt your paper-based feedback required an action by your GP, would you then want to track what exactly happens to your feedback? If yes, why? If no, why not? Is this the same for feedback you leave online too? *(real-time feedback)*

Provider preference

- If you had the option, which of the following three organisations would you prefer to leave paper-based feedback with about your GP: 1) the GP practice 2) an independent organisation 3) a NHS organisation? Why? Is this the same for online too?
- From the three aforementioned methods, which provider would you trust more to do something with your feedback? And why? Is this the same for online and paper-based feedback?

Specific to Online feedback

- Do you believe leaving feedback online will be more effective than leaving it through paper-based methods? If yes, why? If no, why not?
- Do you think your GP will take the feedback you leave online more seriously that the feedback you leave through paper-based methods? If yes, why? If no, why not?
- Do you think you would find it easier to leave feedback online than through other methods? If yes, why? If no, why not?
- Say you had an extreme negative experience when you saw a GP, are you more likely to write to the GP practice with that feedback or are you more likely to leave that feedback online?
- Say you had an extreme positive experience when you saw a GP, are you more likely to write to the GP practice with that feedback or are you more likely to leave that feedback online?

<u>Other</u>

Multi-channel feedback

- Have you ever left feedback for your GP through social media? If yes, how and why? If no, why not?
- If you could leave feedback about your GP on Facebook, would you consider it? If so why? If not, why not?
- Do you want to have the option to be able to leave feedback about your GP through Facebook? If yes, why?
- If you could leave feedback about your GP on Twitter, would you? If so why? If not, why not?

- Would you like to have the option to be able to leave feedback about your GP through Twitter? If yes, why?
- Would you like to have the option to give feedback about your GP through an app on your phone? If yes, why? If no, why not?
- Would you like to have the option to give feedback about your GP by text messaging? If yes, why? If no, why not?
- Would you like to have the option to give feedback about your GP by telephone? If yes, why? If no, why not?

Overall preference on best method to give feedback about GP

- From the following thirteen methods, which three methods would you most prefer to use to leave feedback about your GP (use vignette 3)?

  (The options are: 1) face to face directly to your GP 2) paper-based form that you fill in and place in a comments box at the surgery 3) face to face to the practice manager 4) through the receptionist 5) through the PALs 6) email the practice manager 7) public online website 8) text message (to practice) 9) through an app, and 10) through social media 11) Email the GP directly 12) NHS national patient survey 13) private form on GP website

  a. Why?
  b. Which three methods would you least prefer to use to leave feedback about your GP? Why?
  c. Would you want to use a different method to give negative and positive feedback, or is it the same?
- From the following seven methods you could use to give feedback about your GP, could you rank which you prefer the most? (use vignette 4) The options are 1) email GP 2) email practice 3) online website 4) text message 5) through an app, and 6) social media 7) private form on GP website
  a. Why have you ranked them in this way? (most preferred, and least preferred)
  b. Would you want to use a different method to give negative and positive feedback, or is it the same?

Experience of rating websites

- Have you ever used a rating website? (Like trip advisor or amazon reviews?)
- What was your experience of it?
- Have you ever left feedback on a rating website? If yes, why? If no, why not?

Intention to give feedback, online and offline

- In the near future, do you intend to give feedback about your GP?
  a. If yes, would that be online or using paper-based methods? Why?
  b. If no, why not?
- Has this interview changed your knowledge about giving feedback online to your GP?

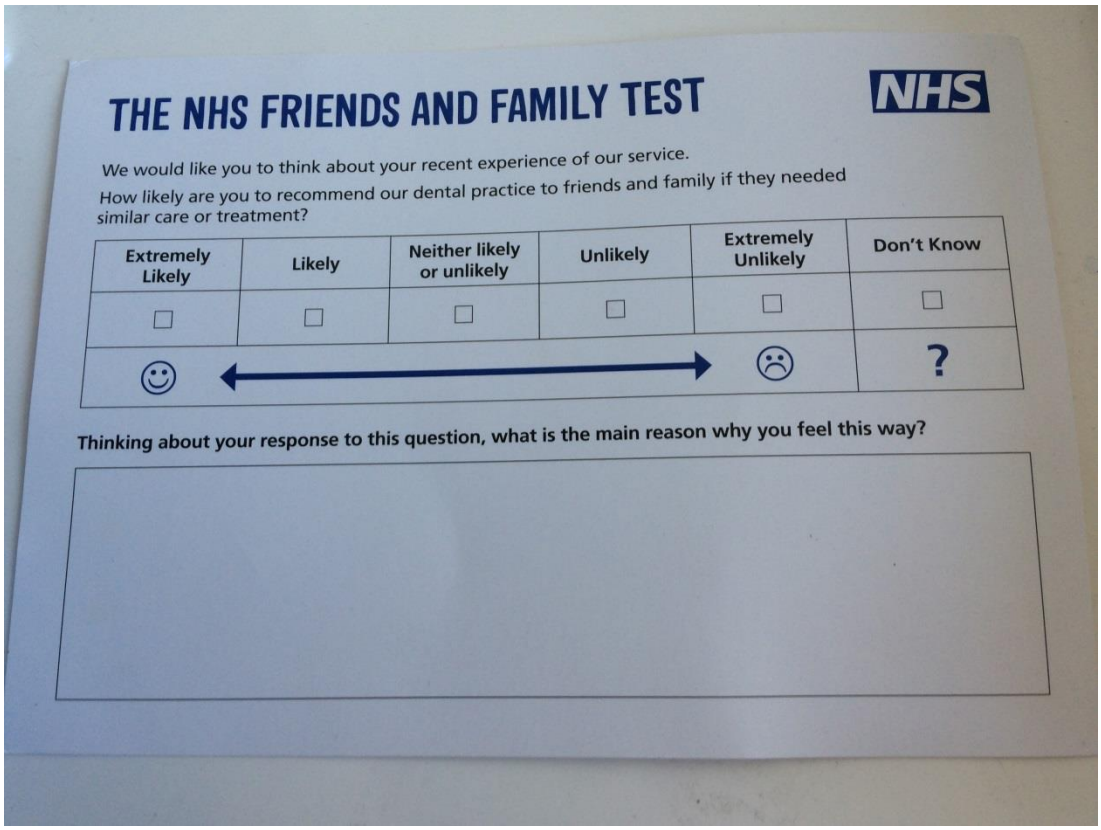
5. Participant background

Age (note gender down)

6. Ending - Any further things they'd like to add and thank them.

ii) Interview materials (Study B)

Two interview materials were used, the first was the NHS Friends and Family Test Card, and the second contained a screenshot of a GP Practice page on the NHS Choices website. Both are copied below.



THE NHS FRIENDS AND FAMILY TEST

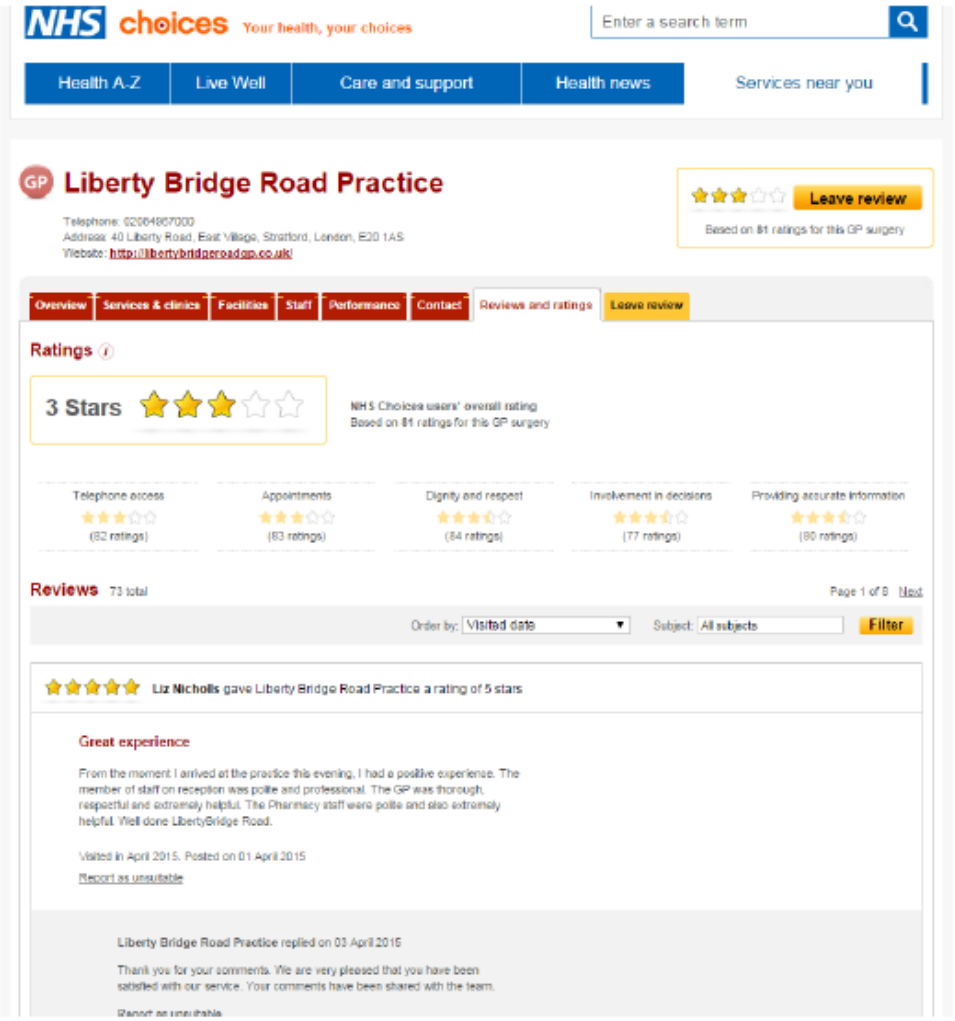
NHS

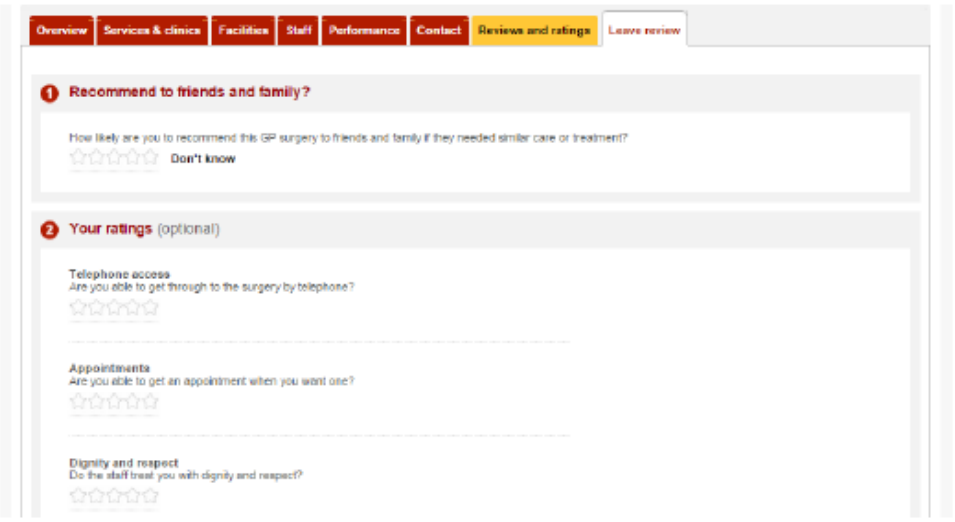
We would like you to think about your recent experience of our service.

How likely are you to recommend our dental practice to friends and family if they needed similar care or treatment?

Extremely Likely	Likely	Neither likely or unlikely	Unlikely	Extremely Unlikely	Don't Know
☐	☐	☐	☐	☐	☐
☺ ⟷				☹	?

Thinking about your response to this question, what is the main reason why you feel this way?


NHS choices
Your health, your choices
Enter a search term
Health A-Z
Live Well
Care and support
Health news
Services near you
Liberty Bridge Road Practice
Telephone: 02084867000
Address: 40 Liberty Road, East Village, Stratford, London, E20 1AS
Website: http://libertybridgeroadgp.co.uk/
Leave review
Based on 81 ratings for this GP surgery
Overview
Services & clinics
Facilities
Staff
Performance
Contact
Reviews and ratings
Leave review
Ratings
3 Stars
NHS Choices users' overall rating
Based on 81 ratings for this GP surgery
Telephone access
(82 ratings)
Appointments
(83 ratings)
Dignity and respect
(84 ratings)
Involvement in decisions
(77 ratings)
Providing accurate information
(80 ratings)
Reviews 73 total
Page 1 of 8 Next
Order by: Visited date
Subject: All subjects
Filter
Liz Nicholls gave Liberty Bridge Road Practice a rating of 5 stars
Great experience
From the moment I arrived at the practice this evening, I had a positive experience. The member of staff on reception was polite and professional. The GP was thorough, respectful and extremely helpful. The Pharmacy staff were polite and also extremely helpful. Well done LibertyBridge Road.
Visited in April 2015. Posted on 01 April 2015
Report as unsuitable
Liberty Bridge Road Practice replied on 03 April 2015
Thank you for your comments. We are very pleased that you have been satisfied with our service. Your comments have been shared with the team.


Overview
Services & clinics
Facilities
Staff
Performance
Contact
Reviews and ratings
Leave review
1 Recommend to friends and family?
How likely are you to recommend this GP surgery to friends and family if they needed similar care or treatment?
Don't know
2 Your ratings (optional)
Telephone access
Are you able to get through to the surgery by telephone?
Appointments
Are you able to get an appointment when you want one?
Dignity and respect
Do the staff treat you with dignity and respect?

iii) Invitation letter (Study B)

Dear Sir/Madam,

Research on public preference and motivation for using online patient feedback

We are undertaking an independent study exploring public preference and motivation for using online patient feedback. As a member of the public, we would be very interested to hear about your experiences of giving feedback to your GP and the possibility of using the internet to give feedback.

Your participation would involve setting aside around forty five minutes to take part in an interview at your place of convenience. The study has research governance approval from the Biomedical & Scientific Research Ethics Committee at the University of Warwick. The enclosed information sheet set out the study in more detail.

If you would be happy to participate in this study, please contact the Chief Investigator Salma Patel by telephone on 07796 141550 or by email at: salma.patel@warwick.ac.uk.

Thank you for your time and we look forward to hearing from you soon.

Yours sincerely,

Salma Patel, Dr Rebecca Cain, Professor Kevin Neailey and Professor Lucy Hooberman

International Digital Laboratory
The University of Warwick
Coventry CV4 7AL United Kingdom
Tel: +44 (0)24 7652 4871
Fax: +44 (0)24 7652 4307
Email: wmg@warwick.ac.uk
Web: www.wmg.warwick.ac.uk

iv) Information sheet (Study B)

Information Sheet for Participants

Interview: Research on public preference and motivation for using online patient feedback

You are invited to participate in this research. Before you decide whether or not to participate it is important for you to understand why the research is being done and what participating will involve. Please take your time to read the following information carefully and ask if anything is unclear.

What is the purpose of this interview?
This interview is the first part of a research study that aims to explore public preference and motivation for using online patient feedback to give feedback to general practitioners. Online patient feedback can be defined as feedback left by patients, carers or service users on public web-based platforms such as NHS Choices, Patient Opinion and iwantgreatcare.org; and on applications such as the iPhone based *Great Care* app.

Do I have to take part?
No. It is up to you to decide whether or not to participate and you are free to stop your involvement at any time without giving a reason. Your decision will not impact in any way on your legal or employment rights.

What would be involved?
After you have agreed to participate, the researcher will arrange a time and place for the interview that is most convenient for you.

At the interview, you will be given the opportunity to ask any questions regarding the interview, and you will be asked to complete a consent form prior to the interview starting.

The interview will take between forty five minutes to an hour, depending on the depth of the discussions.

The discussion between you and the researcher in the interview will be audio recorded for transcription and analysis.

Will my information be kept confidential?
The information you provide to us will be kept confidential, and personal data will be anonymised at transcription. Only members of the research team will have access to your responses. Audio files will be transcribed without making a note of your name. Under no circumstances would identifiable responses be provided to the NHS or any third parties. All data collected will be destroyed at the end of ten years.

If you agree for the audio of your interview being used for dissemination of the research (this is completely optional), it may be placed online or used at conferences to disseminate the research.

All data collection, storage and processing will comply with the principles of the Data Protection Act 1998 and the EU Data Protection Directive 95/46/EC.

What happens at the end of the study?
Study results may be submitted for publication in academic and professional journals, conference proceedings, books, online publications, and used in presentations at conferences and workshops. The results will also be included in the doctoral thesis of Salma Patel.

Who is funding and conducting the research?
The research is being conducted by Salma Patel, a doctoral researcher at the University of Warwick.

It is funded by the Engineering and Physical Sciences Research Council (EPSRC) and is part of the Participation in Healthcare Environment Engineering (PHEE) programme. Further information can be found here: http://tinyurl.com/pheeproject

Who has reviewed the research?
The research has been reviewed and given a favourable opinion by the Biomedical & Scientific Research Ethics Committee at the University of Warwick.

If I wish to discuss the study further who should I contact?
Please contact Salma Patel.

Email: salma.patel@warwick.ac.uk **Phone:** 07796 141550

University Address: International Digital Laboratory, WMG, University of Warwick, Coventry, CV4 7AL.

Who would I contact to complain about this research?
If you are not happy with the way in which this research has been conducted, you should contact the University of Warwick's Deputy Registrar, Nicola Owen (details below).

Email: DeputyRegistrar@warwick.ac.uk **Phone:** 02476 523713

Address: University of Warwick, Gibbet Hill, Coventry, CV4 7AL.

v) The recruitment poster (Study B)

The following recruitment poster was used to recruit participants to Study B.

EPSRC Pioneering research and skills | THE UNIVERSITY OF WARWICK | WMG Innovative Solutions | phee participation in healthcare environment engineering

Research Participants needed

Are you interested in taking part in research?

We are researchers at the University of Warwick & are exploring how and why people like to give feedback about their GP. We would like to interview you, and we hope the results will help inform guidelines for the NHS.

Who? You must be over the age of 18

Where? The interview will take place at a meeting room here in the health centre (in East Village, Stratford).

How long will it take? 35 minutes

How will my data be used? All your data will be anonymised and used for research purposes only.

Interested?

Please call/text:
07796141550

Or email:
salma.patel@warwick.ac.uk

This study has research governance approval from the Biomedical & Scientific Research Ethics Committee at the University of Warwick. Please contact the researcher for further information.

APPENDIX E - ADDITIONAL MATERIAL FOR PHASE 3

This section consists of i) the first draft questionnaire, ii) the analysis plan (including the research questions) iii) tables of amendments made to the questionnaire, and iv) the final questionnaire. In relation to the cognitive interviews this section contains: v) the topic guide, vi) the invitation letter, and vii) the information sheet. In relation to piloting, it contains the viii) invitation letter, ix) information sheet, and x) online consent form.

i) The first draft questionnaire

First draft questionnaire v11 to get expert review – 16/11/15 – PRIVATE AND CONFIDENTIAL

In this survey, you will be asked about how and why you may like to or not like to give feedback to a GP. Feedback refers to reviews, ratings, comments, and complaints. Where there is reference to "GP" in this survey, it means general practitioner. This is the doctor you see when you visit your GP surgery or local health centre. **All of the questions in this survey refer to giving feedback about your experience of receiving care from GPs only.**

Section A: Awareness, history and motivation for giving feedback to GPs (if any)		
A1	Were you aware that you can leave feedback about your experience of receiving care from a GP?	☐ Yes ☐ No **[If Yes, go to A2. If No, go to A3]**
A2	How did you become aware that you could leave feedback about your experience of receiving care from a GP? Select all that apply	I was informed by: ☐ A GP ☐ The GP practice ☐ A friend/family member/colleague ☐ Information on the internet ☐ A NHS leaflet ☐ An advert ☐ A TV programme ☐ Other, please specify below:
A3	Have you ever shared an experience (or story) about the care you received from a GP with your family, friends or colleagues?	☐ Yes ☐ No
A4	Have you ever formally reviewed or given feedback (for example by letter/email/online/feedback form) about the care you have received from a GP?	☐ Yes ☐ No **[If Yes, go to B1. If No, go to A5]**
A5	Why have you not given feedback about your experience of receiving care from a GP? [Rank up to three reasons, with 1 being the one you can most relate to]	☐ Giving feedback is not something I have thought about ☐ I have nothing important to give feedback about ☐ I was not aware that I could leave feedback ☐ I have never experienced exceptionally good service ☐ I have never experienced exceptionally poor service ☐ I do not have time to leave feedback ☐ I am not sure the feedback will reach the GP ☐ I am concerned leaving feedback will impact my relationship with a GP ☐ I believe leaving feedback for GPs will make no difference ☐ I do not want to get the GP into trouble ☐ GPs do not have time to look at feedback that patients leave ☐ Other, please specify below:
Section B: Consideration of giving feedback to GPs in the future, why and when? **All of the questions in this section refer to giving feedback about your experience of receiving care from GPs only.**		
B1	In the near future, would you consider giving feedback about your experience of receiving care from a GP?	☐ Yes ☐ Maybe ☐ Probably not ☐ No **[If Yes or Maybe, go to B2. If No or Probably not, go to B3]**

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B2	Why would you consider giving feedback about a GP? [Rank up to three reasons, with 1 being the one you can most relate to]	☐ I would want someone to improve the service so that it can be better for the next patient ☐ I would want the GP to know how much I appreciate him or her ☐ I would want other people to know about my experience ☐ I believe other people could benefit from knowing about my experience ☐ I believe sharing my experience would make me feel better ☐ I believe sharing my experience would benefit the GP ☐ Other, please specify below [ ] **[Go to B4]**
B3	Why would you not consider giving feedback about a GP? [Rank up to three reasons, with 1 being the one you can most relate to]	☐ I have no desire to give feedback about GPs ☐ I would have nothing important to give feedback about ☐ I have no experience of giving feedback to GPs ☐ I do not have time to give feedback ☐ I am concerned giving feedback will impact my relationship with the GP ☐ I believe leaving feedback for GPs will make no difference ☐ I am not sure the feedback will reach the GP ☐ GPs do not have time to look at feedback that patients leave. ☐ I have concerns about my privacy ☐ I do not want to get the GP into trouble ☐ Other, please specify below: [ ]
B4	When would you be most likely to give feedback about your experience of receiving care from a GP?	☐ Every time I see a GP ☐ After particularly positive experiences only ☐ After particularly negative experiences only ☐ After both positive and negative experiences ☐ Never ☐ Not sure

Section C: Preference on mode of feedback

All of the questions in this section refer to giving feedback about your experience of receiving care from GPs only.

C1 (a)	Imagine you received care from a GP, and you decided to give feedback. For positive and negative experiences, **who** would you most prefer to leave that feedback with?	Feedback about a positive experience	Feedback about a negative experience
		☐	☐ Directly with the GP
		☐	☐ Directly with the GP practice
		☐	☐ A NHS feedback organisation
		☐	☐ An independent feedback organisation
		☐	☐ Other, please specify below:
		[ ]	[ ]

C1 (b)	Please explain your selections	
C2	Imagine you received care from a GP, and you decided to give feedback. For positive and negative experiences, **which methods** are you most likely to use, if they were all available to you? [Rank up to three methods, with 1 being the one that you are most likely to use]	**Feedback about a positive experience** / **Feedback about a negative experience** ☐ ☐ Give feedback face to face to the GP ☐ ☐ Fill in a feedback form/card at the GP practice ☐ ☐ Write a letter to the GP ☐ ☐ Contact the GP practice manager ☐ ☐ Email the GP practice ☐ ☐ Give feedback online on the NHS Choices website ☐ ☐ Give feedback online to an independent feedback website ☐ ☐ Give feedback through an app on my smartphone ☐ ☐ Fill in a private feedback form on the GP practice website ☐ ☐ Give feedback through the receptionist ☐ ☐ Contact the Care Quality Commission ☐ ☐ Give feedback on Facebook ☐ ☐ Give feedback on Twitter ☐ ☐ Other, please specify below: [ ]
C3	Please explain your selections	

Section D: Awareness and consideration of the use of online patient feedback

This section asks you questions about **doctor rating websites**. These websites are where patients and carers can leave feedback about their experience of using health services and receiving care from health care professionals, including doctors and GPs. This feedback is then published on the website, for everyone to see.

D1	Were you aware before today of the existence of doctor rating websites?	☐ Yes ☐ No **[If Yes, go to D2. If No, go to D6]**
D2 (a)	Which specific websites were you aware of? Select all that apply	☐ I wasn't aware of a specific website ☐ *www.NHSchoices.co.uk* ☐ *www.iwantgreatcare.org* ☐ *www.patientopinion.co.uk* ☐ *www.privatehealth.co.uk* ☐ Other, please specify below: [ ]
D2 (b)	How did you become aware? Please select however many that apply	I was informed by: ☐ A GP ☐ The GP practice ☐ A friend/family member/colleague

		☐ Information on the internet ☐ A NHS leaflet ☐ An advert ☐ A TV programme ☐ Other, please specify below: [ ]
D3	Have you used a doctor rating website to: (please select all that apply)	☐ A. look at GP/doctor/consultant/hospital ratings ☐ B. give feedback or review your experience of **the NHS** ☐ C. to give feedback about your experience of receiving care **from a GP** **[If you have selected C, go to D4. Otherwise, go to D6]**
D4	Would you say the majority of feedback you left on this website for a GP or GPs was:	☐ Feedback about a positive experience ☐ Feedback about a negative experience ☐ Feedback about both positive and negative experiences
D5	Thinking about the last time you left feedback for a GP on one of these doctors rating websites, what motivated you to leave feedback about that GP? [Rank up to three reasons, with 1 being the one you can most relate to]	☐ I wanted someone to improve the service so that it can be better for the next patient ☐ I wanted the GP to know how much I appreciate him or her ☐ I wanted other people to know about my experience ☐ I believe other people could benefit from knowing about my experience ☐ I believe sharing my experience would make me feel better ☐ I believe sharing my experience online would be taken more seriously by the GP or the GP practice ☐ I believe sharing my experience would benefit the GP ☐ I wanted to ask other people's advice on my experience ☐ I wanted to know if other people had experienced the same ☐ I was upset at the attitude of the GP ☐ Other, please specify below: [ ]
D6	In the near future, would you consider using a doctor rating website to give feedback about your experience of receiving care from a GP?	☐ Yes ☐ Maybe ☐ Probably not ☐ No **[If Yes or Maybe, go to D7. If No or Probably not, go to D9]**
D7	Why? [Rank up to three reasons, with 1 being the one you can most relate to]	☐ I would want someone to improve the service so that it can be better for the next patient ☐ I would want the GP to know how much I appreciate him or her ☐ I would want other people to know about my experience ☐ I believe other people could benefit from knowing about my experience ☐ I believe sharing my experience would make me feel better ☐ I believe sharing my experience online would be taken

		more seriously by the GP or the GP practice ☐ I believe sharing my experience would benefit the GP ☐ I believe I would find it easier to give it online rather than using other methods to give feedback ☐ I may be upset at the attitude of the GP ☐ Other, please specify below: [ ]
D8 (a)	Which of the following would you prefer to use to leave feedback publicly **online** about your experience of receiving care from a GP?	☐ A computer/laptop ☐ An app on your smartphone/other device ☐ Other, please specify below: [ ]
D8 (b)	Please explain your choice	**[Go to D10]**
D9	Why not? [Rank up to three reasons, with 1 being the one you can most relate to]	☐ I have no desire to leave feedback about GPs, regardless of whether it is online or not. ☐ I would have nothing important to give feedback about ☐ I do not have access to a computer or internet ☐ I have no experience of using such websites ☐ I do not have time to leave feedback on such websites ☐ I am concerned leaving feedback online will impact my relationship with the GP ☐ I do not believe leaving feedback for GPs online will make a difference ☐ I am not sure the feedback will reach the GP ☐ GPs do not have time to look at feedback I leave online ☐ I have concerns about my privacy online ☐ I do not want to get the GP into trouble ☐ I would prefer to leave feedback for a GP privately ☐ Other, please specify below: [ ]
D10	When would you be most likely to give feedback online about your experience of receiving care from a GP?	☐ Every time I see a GP ☐ After particularly positive experiences only ☐ After particularly negative experiences only ☐ After both positive and negative experiences ☐ Never ☐ Not sure
Section E: Feedback in public or private		
E1 (a)	Would you like the feedback you and other patients give about your experience of receiving care from a GP to be online, and therefore in the public domain for everyone to see?	☐ Yes ☐ Maybe ☐ Probably not ☐ No

E1 (b)	Please explain your choice	
Section F: Anonymity and privacy **All of the questions in this section refer to giving feedback about your experience of receiving care from GPs only.**		
F1 (a)	Would you leave your real name on feedback you give to the GP practice privately?	☐ No ☐ Yes, on feedback about positive experiences only ☐ Yes, on feedback about negative experiences only ☐ Yes, on feedback about both positive and negative experiences ☐ I have no intention of giving feedback about a GP to the GP practice privately
F1 (b)	Please explain your choice	
F2 (a)	Would you leave your real name on feedback you leave publicly online?	☐ No ☐ Yes, on feedback about positive experiences only ☐ Yes, on feedback about negative experiences only ☐ Yes, on feedback about both positive and negative experiences ☐ I have no intention of leaving feedback about a GP online
F2 (b)	Please explain your choice	
F3 (a)	Would you mention a GP by name on feedback you give to the GP practice privately?	☐ No ☐ Yes, on feedback about positive experiences only ☐ Yes, on feedback about negative experiences only ☐ Yes, on feedback about both positive and negative experiences ☐ I have no intention of giving feedback about a GP to the GP practice privately
F3 (b)	Please explain your choice	
F4 (a)	Would you mention a GP by name on feedback you leave publicly online?	☐ No ☐ Yes, on feedback about positive experiences only ☐ Yes, on feedback about negative experiences only ☐ Yes, on feedback about both positive and negative experiences ☐ I have no intention of leaving feedback about a GP online
F4 (b)	Please explain your choice	
Section G: Other factors that may be affecting patient intention to give feedback to GPs		

G1	Do you have a long term condition?	☐ Yes ☐ No
G2	Have you used the internet in the past to search for health information?	☐ Yes ☐ No
G3	Roughly, how many GPs are there in your current GP practice?	☐ 1 GP ☐ 2-3 GPs ☐ 4-5 GPs ☐ 6-9 GPs ☐ More than 10 GPs ☐ I do not know
Section H: Socio-demographics		
H1	What is your gender?	☐ Male ☐ Female
H2	How old are you?	☐ 18-19 ☐ 20-21 ☐ 22-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60-64 ☐ 65 or more
H3	What is your highest level of qualification?	☐ Postgraduate level qualification (or equivalent) ☐ Degree level qualification (or equivalent) ☐ Higher educational qualification below degree level ☐ A-Levels or Highers ☐ ONC / National Level BTEC ☐ GCSE or O level equivalent (Grade A-C) ☐ GCSE grade D-G or CSE grade 2-5 or Standard Grade level 4-6 ☐ Other qualifications (inc. foreign quals below degree level) ☐ No formal qualifications
H4	Where do you live?	☐ North East ☐ North West ☐ Yorkshire and the Humber ☐ East Midlands ☐ West Midlands ☐ East of England ☐ South East ☐ South West ☐ Inner London ☐ Outer London
H5	What is your total annual household income before any taxes or other deductions?	☐ Less than £ 5000 per year ☐ £5000 to £9999 ☐ £10 000 to £14 999 ☐ £15 000 to £19 999 ☐ £20 000 to £24 999 ☐ £25 000 to £29 999 ☐ £30 000 to £39 999 ☐ £40 000 to £49 999 ☐ £50 000 to £69 999 ☐ £70 000 to £100 000 ☐ More than £100 000 ☐ I prefer not to say ☐ I do not know

ii) the analysis plan (including the research questions)

Statistical Analysis Plan (and research questions) for the Questionnaire (approved by academic statistician in Nov 2015)				
Section A: Awareness, history and motivation for giving feedback about GPs (if any)			**Source**	**Research question & statistical test**
A1	Were you aware that you can leave feedback about your experience of receiving care from a GP?	☐ Yes ☐ No **[If Yes, go to A2. If No, go to A3]**	Question and scale developed by the researcher; derived from study B	**RQ1. To what extent are patients in the UK aware that they can leave feedback about their experience of receiving care from GPs?** (Descriptive statistics (Frequency Table) of A1) a. **Are patients more likely to be aware if they are from a certain age group/gender/education level/long term condition/live in a certain region of the UK?** (between A1 and G1, H2, H3, H4: individually do a contingency table and chi square test or fisher's exact test; and then followed by a logistic regression for all variables to find the odds ratio) b. **How did they become aware?** (Descriptive statistics (Frequency Table) of A2) ("Other" will be coded prior to that)
A2	How did you become aware that you could leave feedback about your experience of receiving care from a GP? Select all that apply	I was informed by: ☐ A GP ☐ The GP practice ☐ A friend/family member/colleague ☐ Information on the internet ☐ A NHS leaflet ☐ An advert ☐ A TV programme ☐ Other, please specify below: [ ]	Question and scale developed by the researcher.	
A3	Have you ever shared an experience (or story) about the care you received from a GP with your family, friends or colleagues?	☐ Yes ☐ No	Question and scale adapted from (Patient Opinion, 2015)	RQ2. Are patients sharing their experiences of receiving care from GPs with acquaintances but not reporting them formally? If so, why are they not formally reporting them? a) **What percentage of**
A4	Have you ever formally reviewed or given feedback (for example by letter/email/online/feedback form) about the care you have received from a GP?	☐ Yes ☐ No **[If Yes, go to B1. If No, go to A5]**	Question and scale adapted from (Patient Opinion, 2015)	

				patients shared feedback informally but did not share feedback formally? (do a contingency table analysis (cross tabulation) between A3 and A4) b) **Are the patients that have shared feedback informally more likely to share it formally?** (Between A3 and A4 do a contingency table and chi square test or fisher's exact test; and then followed by a logistic regression for all variables to find the odds ratio) c) **Is there a relationship between those that have shared feedback formally and age group/gender/education level/long term condition/live in a certain region of the UK?** (between A4 and G1, H2, H3, H4: individually do a contingency table and chi square test or fisher's exact test; and then do a logistic regression for all variables to find the odds ratio)
A5	Why have you not given feedback about your experience of receiving care from a GP? **[Rank up to three reasons, with 1 being the one you can most relate to]**	☐ Giving feedback is not something I have thought about ☐ I have nothing important to give feedback about ☐ I was not aware that I could leave feedback ☐ I have never experienced exceptionally good service ☐ I have never experienced exceptionally poor service ☐ I do not have time to leave feedback	Question developed by the researcher; scale derived from the results of study B	d) **What are the reasons for patients not formally reporting their feedback for a GP?** (Descriptive statistics (Frequency Table) of responses to A5

		☐ I am not sure the feedback will reach the GP ☐ I am concerned leaving feedback will impact my relationship with a GP ☐ I believe leaving feedback for GPs will make no difference ☐ I do not want to get the GP into trouble ☐ GPs do not have time to look at feedback that patients leave ☐ Other, please specify below: [ ]		[Rank1, Rank2, and Rank3.]
Section B: Consideration of giving feedback about GPs in the future, why and when? **All of the questions in this section refer to giving feedback about your experience of receiving care from GPs only.**			**Source**	**Research question & statistical test**
B1	In the near future, would you consider giving feedback about your experience of receiving care from a GP?	☐ Yes ☐ Maybe ☐ Probably not ☐ No **[If Yes or Maybe, go to B2. If No or Probably not, go to B3]**	Question and scale developed by the researcher; derived from study B	RQ3) How many patients would consider or not consider leaving feedback about a GP in the near future and why or why not? What type of experience would motivate them to consider leaving feedback in the future? a. **How many patients would consider leaving feedback about their GP and how many would not?** (Descriptive statistics (Frequency Table) of B1) b. **Is there a relationship between those that would consider giving feedback and age group/gender/education level/long term condition/live in a certain region of the UK?** (Create

				new variable which combines "Yes,Maybe" into Yes and "No, Probably" into No. Then between this new variable and G1, H2, H3, H4: individually do a contingency table and chi square test or fisher's exact test; and then followed by a logistic regression for all variables to find the odds ratio)
B2	Why would you consider giving feedback about a GP? [Rank up to three reasons, with 1 being the one you can most relate to]	☐ I would want someone to improve the service so that it can be better for the next patient ☐ I would want the GP to know how much I appreciate him or her ☐ I would want other people to know about my experience ☐ I believe other people could benefit from knowing about my experience ☐ I believe sharing my experience would make me feel better ☐ I believe sharing my experience would benefit the GP ☐ Other, please specify below **[Go to B4]**	Question developed by the researcher, scales derived from the results of study B and some partly adapted from (Patient Opinion, 2015)	c. **What are the top 3 reasons for patients considering giving feedback about their GP?** (Descriptive statistics (Frequency Table) of responses to B2 [Rank1, Rank2, and Rank3].
B3	Why would you not consider giving feedback about a GP? [Rank up to three reasons, with 1 being the one you can most relate to]	☐ I have no desire to give feedback about GPs ☐ I would have nothing important to give feedback about ☐ I have no experience of giving feedback to GPs ☐ I do not have time to give feedback ☐ I am concerned giving feedback will impact my relationship with the GP	Question developed by the researcher; scale derived from results of study B.	d. **What are the top 3 reasons for patients not considering giving feedback about their GP?** (Descriptive statistics (Frequency Table) of responses to B3 Rank1,

		☐ I believe leaving feedback for GPs will make no difference ☐ I am not sure the feedback will reach the GP ☐ GPs do not have time to look at feedback that patients leave. ☐ I have concerns about my privacy ☐ I do not want to get the GP into trouble ☐ Other, please specify below: [ ]		Rank2, and Rank3.
B4	When would you be most likely to give feedback about your experience of receiving care from a GP?	☐ Every time I see a GP ☐ After particularly positive experiences only ☐ After particularly negative experiences only ☐ After both positive and negative experiences ☐ Never ☐ Not sure	Question developed by the researcher; scales derived from the results of study B and partly adapted from (Galizzi et al., 2012)'s survey	e. **When are patients most likely to give feedback about their GP?** (Descriptive statistics (Frequency Table) of responses to B4.
Section C: Preference on mode of feedback **All of the questions in this section refer to giving feedback about your experience of receiving care from GPs only.**			**Source**	**Research question & statistical test**
C1 (a)	Imagine you received care from a GP, and you decided to give feedback. For positive and negative experiences, **who** would you most prefer to leave that feedback with?	Feedback about a positive experience ☐ ☐ ☐ ☐ ☐ [ ] Feedback about a negative experience ☐ Directly with the GP ☐ Directly with the GP practice ☐ A NHS feedback organisation ☐ An independent feedback organisation ☐ Other, please specify below: [ ]	Question developed by researcher; scales derived from results of study B	RQ4) Do patients prefer to leave feedback with the GP, the GP practice, the NHS or an independent third party, and why? And does this differ depending on whether the feedback is negative or positive? a. **Who is the most and least preferred person/organisation for positive feedback?** (Descriptive statistics (Frequency Table) of responses to C1ai) b. **Who is the most and least preferred person/organisation for**

				negative feedback? (Descriptive statistics (Frequency Table) of responses to C1aii) c. **Is there a significant difference between patients' preference for who to leave feedback with based on whether their feedback is of a negative or positive experience?** (a contingency table between C1ai and C1aii and McNemar's test) d. **If c is no, who is the overall most/least preferred "person/organisation" to leave feedback with?** (calculate most and least preferred from the Descriptive statistics (Frequency Table) of responses to C1ai and C1aii) e. **Is there a relationship between consideration of who to leave positive feedback with and age group/gender/education level/long term condition/live in a certain region of the UK?** (between C1ai and G1, H2, H3, H4: individually do a contingency table and multinomial model) f. **Is there a relationship between consideration of**

				who to leave negative feedback with and age group/gender/education level/long term condition/live in a certain region of the UK? (between C1aii and G1, H2, H3, H4: individually do a contingency table and chi square test or fisher's exact test) g.
C1 (b)	Please explain your selections		Question developed by researcher.	(Explanations will be coded using content analysis)
C2	Imagine you received care from a GP, and you decided to give feedback. For positive and negative experiences, **which methods** are you most likely to use, if they were all available to you? [Rank up to three methods, with 1 being the one that you are most likely to use]	Feedback about a positive experience ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Feedback about a negative experience ☐ Give feedback face to face to the GP ☐ Fill in a feedback form/card at the GP practice ☐ Write a letter to the GP ☐ Contact the GP practice manager ☐ Email the GP practice ☐ Give feedback online on the NHS Choices website ☐ Give feedback online to an independent feedback website ☐ Give feedback through an app on my smartphone ☐ Fill in a private feedback form on the GP practice website	Question developed by researcher; scales derived from results of study B	RQ5) Which methods are patients most likely to use to leave feedback for GPs in the near future, and why? Also, are patients likely to use different methods for feedback about a positive and negative experience? a. **Which is the most and least preferred method for feedback about a positive experience?** (Descriptive statistics (Frequency Table) of responses to C2ai (rank1, rank2, rank3)) b. **Which is the most and least preferred method for feedback about a**

		☐ Give feedback through the receptionist ☐ Contact the Care Quality Commission ☐ Give feedback on Facebook ☐ Give feedback on Twitter ☐ Other, please specify below: [ ]		**negative experience?** (Descriptive statistics (Frequency Table) of responses to C2ai (rank1, rank2, rank3)) c. **Is there a significant difference between patients' preference for which method to use based on whether their feedback is of a negative or positive experience?** (compare results of a and b; could do a McNemar's test) d. **If c is no, which are the overall most/least preferred methods to leave feedback?** (calculate most and least preferred from the Descriptive statistics (Frequency Table) of responses to C2ai and C2aii) e. **Is there a relationship between preference of method for leaving feedback about positive experiences and age group/gender/education level/long term condition/live in a certain region of the UK?** (between C2ai and G1, H2, H3, H4: individually do a contingency table and chi square test or fisher's exact test, and could do a multinomial model) f. **Is there a relationship**

				between consideration of who to leave negative feedback with and age group/gender/education level/long term condition/live in a certain region of the UK? (between C2aii and G1, H2, H3, H4: individually do a contingency table and chi square test or fisher's exact test and could do a multinomial model)
C3	Please explain your selections		Question developed by researcher.	(Explanations will be coded using content analysis)
Section D: Awareness and consideration of the use of online patient feedback This section asks you questions about **doctor rating websites**. These websites are where patients and carers can leave feedback about their experience of using health services and receiving care from health care professionals, including doctors and GPs. This feedback is then published on the website, for everyone to see.			**Source**	**Research question & statistical test**
D1	Were you aware before today of the existence of doctor rating websites?	☐ Yes ☐ No **[If Yes, go to D2. If No, go to D6]**	Question and scale developed by researcher	**RQ6) To what extent are patients in the UK aware of the existence of doctor rating websites?** (Descriptive statistics (Frequency Table) of D1) a. **Are patients more likely to be aware if they are from a certain age group/gender/education level/long term condition/live in a certain region of the UK/have searched for health information online before?** (between D1 and

				G1, H2, H3, H4, G3: individually do a contingency table and chi square test or fisher's exact test; and then followed by a logistic regression for all variables to find the odds ratio) b. **How does this awareness differ with patient awareness of being able to leave feedback for a GP, regardless of whether it is online or not. (cf. with A1).** (between D1 and A1 do a contingency table and chi square test or fisher's exact test; and then find odds ratio) c. Does the characteristics of the patients in each group (awareness of giving feedback generally and awareness of giving feedback online) differ, and if so, on which factors? (compare results of RQ6a) and RQ1a))
D2 (a)	Which specific websites were you aware of? Select all that apply	☐ I wasn't aware of a specific website ☐ *www.NHSchoices.co.uk* ☐ *www.iwantgreatcare.org* ☐ *www.patientopinion.co.uk* ☐ *www.privatehealth.co.uk* ☐ Other, please specify below: [ ]	Question and scale developed by researcher	**RQ7) Which websites are patients most aware of?** (Descriptive statistics (Frequency Table) of D2)

D2 (b)	How did you become aware? Please select however many that apply	I was informed by: ☐ A GP ☐ The GP practice ☐ A friend/family member/colleague ☐ Information on the internet ☐ A NHS leaflet ☐ An advert ☐ A TV programme ☐ Other, please specify below: [ ]	Question and scale developed by researcher	**RQ7a) How did patients become aware?** (Descriptive statistics (Frequency Table) of D2b)) ("Other" will be coded prior to that)
D3	Have you used a doctor rating website to: (please select all that apply)	☐ A. look at GP/doctor/consultant/hospital ratings ☐ B. give feedback or review your experience of **the NHS** ☐ C. to give feedback about your experience of receiving care **from a GP** **[If you have selected C, go to D4. Otherwise, go to D6]**	Question and scale developed by researcher	**RQ8) What have patients used doctor rating websites for?** (Descriptive statistics (Frequency Table) of responses to D3 (up to three variables))
D4	Would you say the majority of feedback you left on this website for a GP or GPs was:	☐ Feedback about a positive experience ☐ Feedback about a negative experience ☐ Feedback about both positive and negative experiences	Question developed by the researcher; scales derived from results of study B	**RQ9) What type of feedback have patients left on doctor rating websites?** (Descriptive statistics (Frequency Table) of D4.
D5	Thinking about the last time you left feedback for a GP on one of these doctors rating websites, what motivated you to leave feedback about that GP? [Rank up to three reasons, with 1 being the one you can most relate to]	☐ I wanted someone to improve the service so that it can be better for the next patient ☐ I wanted the GP to know how much I appreciate him or her ☐ I wanted other people to know about my experience ☐ I believe other people could benefit from knowing about my experience ☐ I believe sharing my experience would make me feel better ☐ I believe sharing my experience online would be taken more seriously by the GP or the GP practice ☐ I believe sharing my experience would benefit the GP ☐ I wanted to ask other people's advice on my experience ☐ I wanted to know if other people had experienced the	Question developed by the researcher, scales derived from the results of study B and some partly adapted from (Patient Opinion, 2015)	**RQ10) What motivated patients to leave feedback for a GP on a doctor rating website?** (Descriptive statistics (Frequency Table) of responses to D5 [Rank1, Rank2, and Rank3].

		same ☐ I was upset at the attitude of the GP ☐ Other, please specify below: [ ]		
D6	In the near future, would you consider using a doctor rating website to give feedback about your experience of receiving care from a GP?	☐ Yes ☐ Maybe ☐ Probably not ☐ No **[If Yes or Maybe, go to D7. If No or Probably not, go to D9]**	Question and scale developed by the researcher.	RQ13) Would patients consider giving feedback on doctor rating websites in the near future? a. **How many patients would consider leaving feedback on doctor raring website?** (Descriptive statistics (Frequency Table) of D6) b. **Is there a relationship between those that would consider using a doctor rating website and age group/gender/education level/long term condition/live in a certain region of the UK/no of GPs in practice/searched for health information online before?** (Create new variable which combines "Yes,Maybe" into Yes and "No, Probably" into No. Then between this new variable and G1, H2, H3, H4, G2, G3: individually do a contingency table and chi square test or fisher's exact test; and then followed by a logistic regression for all variables

				to find the odds ratio) c. **How does this consideration for future use differ with consideration for leave feedback for a GP, regardless of whether it is online or not? (cf. with B1).** (between D6 and B1 do a contingency table and chi square test or fisher's exact test; and then find odds ratio) d. **Does the characteristics of the patients in each group as above differ, and if so, on which factors? (compare results of RQ13b) and RQ3b))**
D7	Why? [Rank up to three reasons, with 1 being the one you can most relate to]	☐ I would want someone to improve the service so that it can be better for the next patient ☐ I would want the GP to know how much I appreciate him or her ☐ I would want other people to know about my experience ☐ I believe other people could benefit from knowing about my experience ☐ I believe sharing my experience would make me feel better ☐ I believe sharing my experience online would be taken more seriously by the GP or the GP practice ☐ I believe sharing my experience would benefit the GP ☐ I believe I would find it easier to give it online rather than using other methods to give feedback ☐ I may be upset at the attitude of the GP ☐ Other, please specify below:	Question developed by the researcher, scales derived from the results of study B and some partly adapted from (Patient Opinion, 2015)	**RQ14) Why would patients consider leaving feedback for a GP on a doctor rating website?** (Descriptive statistics (Frequency Table) of responses to D7; [Rank1, Rank2, and Rank3].

D8 (a)	Which of the following would you prefer to use to leave feedback publicly **online** about your experience of receiving care from a GP?	☐ A computer/laptop ☐ An app on your smartphone/other device ☐ Other, please specify below: [ ]	Question and scale developed by researcher	**RQ15) Using which device would patients prefer to leave feedback online?** (Descriptive statistics (Frequency Table) of responses to D8) a. **Is there a relationship between this preference and age group/gender/education level/long term condition/live in a certain region of the UK?** (between D8 and G1, H2, H3, H4: individually do a contingency table and chi square test or fisher's exact test)
D8 (b)	Please explain your choice	**[Go to D10]**	Question developed by researcher	(Explanations will be coded using content analysis)
D9	Why not? [Rank up to three reasons, with 1 being the one you can most relate to]	☐ I have no desire to leave feedback about GPs, regardless of whether it is online or not. ☐ I would have nothing important to give feedback about ☐ I do not have access to a computer or internet ☐ I have no experience of using such websites ☐ I do not have time to leave feedback on such websites ☐ I am concerned leaving feedback online will impact my relationship with the GP ☐ I do not believe leaving feedback for GPs online will make a difference ☐ I am not sure the feedback will reach the GP ☐ GPs do not have time to look at feedback I leave	Question developed by the researcher; scale derived from results of study B	**RQ16) Why would patients consider leaving feedback for a GP on a doctor rating website?** (Descriptive statistics (Frequency Table) of responses to D9 [Rank1, Rank2, and Rank3].

		online ☐ I have concerns about my privacy online ☐ I do not want to get the GP into trouble ☐ I would prefer to leave feedback for a GP privately ☐ Other, please specify below: [ ]		
D10	When would you be most likely to give feedback online about your experience of receiving care from a GP?	☐ Every time I see a GP ☐ After particularly positive experiences only ☐ After particularly negative experiences only ☐ After both positive and negative experiences ☐ Never ☐ Not sure	Question developed by the researcher; scales derived from the results of study B and partly adapted from (Galizzi et al., 2012)'s survey	**RQ17) What type of experience would motivate patients to consider leaving feedback online in the future?** (Descriptive statistics (Frequency Table) of responses to D10) h. **How does this compare to when the feedback was not online in B4? Is there a significant difference?** (a contingency table between D10 and B4)
Section E: Feedback in public or private				
E1 (a)	Would you like the feedback you and other patients give about your experience of receiving care from a GP to be online, and therefore in the public domain for everyone to see?	☐ Yes ☐ Maybe ☐ Probably not ☐ No	Question and scale developed by researcher	**RQ18) Would patients want the feedback they leave for a GP to be in the public domain, if so why, if not why not?** *(Descriptive statistics (Frequency Table) of responses to E1a and E1b)* a. **Is there a relationship between this preference and age group/gender/education level/long term condition/live in a certain region of the UK/ /no of GPs in practice/searched for health information**

				online before? *(between E1 and G1, H2, H3, H4, G2, G3: do a contingency table and chi square test or fisher's exact test)*
E1 (b)	Please explain your choice		Question developed by researcher	(Explanations will be coded using content analysis)
Section F: Anonymity and privacy **All of the questions in this section refer to giving feedback about your experience of receiving care from GPs only.**			**Source**	**Research question & statistical test**
F1 (a)	Would you leave your real name on feedback you give to the GP practice privately?	☐ No ☐ Yes, on feedback about positive experiences only ☐ Yes, on feedback about negative experiences only ☐ Yes, on feedback about both positive and negative experiences ☐ I have no intention of giving feedback about a GP to the GP practice privately	Question and scale developed by researcher.	**RQ18) Will patients consider leaving their real name in any feedback they may leave privately about GPs in the near future?** (Descriptive statistics (Frequency Table) of responses to F1a and F1b) a. **Is there a relationship between this consideration and age group/gender/education level/long term condition/live in a certain region of the UK/ /no of GPs in practice/searched for health information online before?** (between F1 and G1, H2, H3, H4, G2, G3: individually do a contingency table and chi square test or fisher's exact test)
F1 (b)	Please explain your choice		Question developed by researcher	(Explanations will be coded using content analysis)

F2 (a)	Would you leave your real name on feedback you leave publicly online?	☐ No ☐ Yes, on feedback about positive experiences only ☐ Yes, on feedback about negative experiences only ☐ Yes, on feedback about both positive and negative experiences ☐ I have no intention of leaving feedback about a GP online	Question and scale developed by the researcher	**RQ19) Will patients consider leaving their real name in any feedback they may leave publicly about GPs in the near future?** (Descriptive statistics (Frequency Table) of responses to F2a and F2b) a. **Is there a relationship between this consideration and age group/gender/education level/long term condition/live in a certain region of the UK/ /no of GPs in practice/searched for health information online before?** (between F2 and G1, H2, H3, H4, G2, G3: individually do a contingency table and chi square test or fisher's exact test)
F2 (b)	Please explain your choice			(Explanations will be coded using content analysis)
F3 (a)	Would you mention a GP by name on feedback you give to the GP practice privately?	☐ No ☐ Yes, on feedback about positive experiences only ☐ Yes, on feedback about negative experiences only ☐ Yes, on feedback about both positive and negative experiences ☐ I have no intention of giving feedback about a GP to the GP practice privately	Question and scale developed by the researcher	**RQ20) Would patients consider leaving the GP's name in any feedback they may leave privately in the future, and why?** (Descriptive statistics (Frequency Table) of responses to F3a and F3b) a. **Is there a relationship between this and age group/gender/education level/long term condition/live in a certain**

				region of the UK/ /no of GPs in practice/searched for health information online before? (between F3 and G1, H2, H3, H4, G2, G3: individually do a contingency table and chi square test or fisher's exact test)
F3 (b)	Please explain your choice		Question developed by researcher	(Explanations will be coded using content analysis)
F4 (a)	Would you mention a GP by name on feedback you leave publicly online?	☐ No ☐ Yes, on feedback about positive experiences only ☐ Yes, on feedback about negative experiences only ☐ Yes, on feedback about both positive and negative experiences ☐ I have no intention of leaving feedback about a GP online	Question and scale developed by the researcher	**RQ20) Would patients consider leaving the GP's name in any feedback they may leave publicly in the future, and why?** (Descriptive statistics (Frequency Table) of responses to F4a and F4b) b. **Is there a relationship between this and age group/gender/education level/long term condition/live in a certain region of the UK/ /no of GPs in practice/searched for health information online before?** (between F3 and G1, H2, H3, H4, G2, G3: individually do a contingency table and chi square test or fisher's exact test)
F4 (b)	Please explain your choice		Question developed by researcher	(Explanations will be coded using content analysis)

Section G: Other factors that may be affecting patient intention to give feedback about GPs			**Source**	**Research question & statistical test**
G1	Do you have a long term condition?	☐ Yes ☐ No	Question and scale developed by the researcher	Covered in the previous part of the questionnaire.
G2	Have you used the internet in the past to search for health information?	☐ Yes ☐ No	Question and scale derived directly from (Galizzi et al., 2012)	Covered in the previous part of the questionnaire.
G3	Roughly, how many GPs are there in your current GP practice?	☐ 1 GP ☐ 2-3 GPs ☐ 4-5 GPs ☐ 6-9 GPs ☐ More than 10 GPs ☐ I do not know	Question and scale developed by the researcher	Covered in the previous part of the questionnaire.
Section H: Socio-demographics				
H1	What is your gender?	☐ Male ☐ Female	Question and scale adapted from the English national census (Office for National Statistics, 2011)	Covered in the previous part of the questionnaire.
H2	How old are you?	☐ 18-19 ☐ 20-21 ☐ 22-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60-64 ☐ 65 or more	Question and scale derived from the Workplace Employee Relations Survey, 2004 (Department of Trade and Industry, 1998)	Covered in the previous part of the questionnaire.
H3	What is your highest level of qualification?	☐ Postgraduate level qualification (or equivalent) ☐ Degree level qualification (or equivalent) ☐ Higher educational qualification below degree level ☐ A-Levels or Highers ☐ ONC / National Level BTEC	Question and scale adapted from the Opinions and Lifestyle Survey, 2013 (Office for National Statistics, 2013)	Covered in the previous part of the questionnaire.

		☐ GCSE or O level equivalent (Grade A-C) ☐ GCSE grade D-G or CSE grade 2-5 or Standard Grade level 4-6 ☐ Other qualifications (inc. foreign quals below degree level) ☐ No formal qualifications		
H4	Where do you live?	☐ North East ☐ North West ☐ Yorkshire and the Humber ☐ East Midlands ☐ West Midlands ☐ East of England ☐ South East ☐ South West ☐ Inner London ☐ Outer London	Question and scale derived from the English national census (Office for National Statistics, 2011)	Covered in the previous part of the questionnaire.
H5	What is your total annual household income before any taxes or other deductions?	☐ Less than £ 5000 per year ☐ £5000 to £9999 ☐ £10 000 to £14 999 ☐ £15 000 to £19 999 ☐ £20 000 to £24 999 ☐ £25 000 to £29 999 ☐ £30 000 to £39 999 ☐ £40 000 to £49 999 ☐ £50 000 to £69 999 ☐ £70 000 to £100 000 ☐ More than £100 000 ☐ I prefer not to say ☐ I do not know	Question and scale adapted from the British Election Study Continuous Monitoring Survey, 2008-2010 (Sanders and Whiteley, 2014).	Covered in the previous part of the questionnaire.

iii) Tables of amendments made to the questionnaire

The following tables (Table 0-1 to Table 0-6) illustrate the amendments made to the various drafts of the questionnaire.

Table 0-1: Summary of amendments made to the first draft questionnaire based on academic expert reviews

Domain	Question item	Comment	Action
Section A: Awareness, history and motivation for giving feedback about GPs (if any)	A3: Have you ever shared an experience (or story) about the care you received from a GP with your family, friends or colleagues?	Maybe specify that this is 'informal' to clearly separate it from formal feedback or say 'in conversation'	Question revised to: Have you ever shared an experience (or story) informally about the care you received from a GP with your family, friends or colleagues?
	A4: Have you ever formally reviewed or given feedback (for example by letter/email/online/feedback form) about the care you have received from a GP?	I would take "review" out because it slightly complicates the question and reviewing a service is part of giving feedback	Question revised to: Have you ever formally given feedback (for example by letter/email/online/feedback form) about the care you have received from a GP?
	A5: Why have you not given feedback about your experience of receiving care from a GP?	'Why' sounds a bit confrontational or critical; 'reasons' may avoid invoking a defensive reaction	Question revised to: What are the reasons you have not given feedback about your experience of receiving care from a GP?
Section B: Consideration of giving feedback about GPs in the future, why and when?	B1: In the near future, would you consider giving feedback about your experience of receiving care from a GP?	Suggest you add 'if you have an appointment with your GP' because it's a hypothetical question; add in the hypothetical scenario	Question revised to: In the near future, if you have an appointment with your GP, would you consider giving feedback about your experience of receiving care from a GP?
	B2 & B3: Why would you consider/not consider giving feedback about a GP?	'Why' or 'Why not' sounds a bit confrontational or critical; 'reasons' may avoid invoking a defensive reaction	Questions have been revised to: What are the reasons for you/ you not considering giving feedback about a GP?
	B4: When would you be most likely to give feedback about your experience of receiving care from a GP?	Could one item on the response scale be 'if asked to give feedback by the GP practice'?	Two further scales have now been added with the option to select up to two reasons: • If the GP asked me to leave feedback • If the GP practice asked me to leave feedback
Section C: Preference on mode of feedback	C2: Imagine you received care from a GP, and you decided to give feedback. For positive and negative experiences, **which methods** are you most likely to use, if they were all available to you?	Is it worth mentioning the Patient Advice and Liaison Service (PALS) as a method?	PALS has now been added on as an additional scale.
Section D: Awareness and consideration of the use of OPF	D7: Why? & D9: Why not?	'Why' or 'Why not' sounds a bit confrontational or critical; it could be revised to 'please state your reasons'	Although 'please state your reasons' may sounds less direct; this is a face-to-face interview and a conservation, and why would be better suited, but the questions have been revised to 'May I ask why/why not?' to make them less confrontational
	D8a: Which of the following would you prefer to use to leave feedback publicly **online** about your experience of receiving care from a	Define what publicly means in the question	Question revised to: Which of the following would you prefer to use to leave feedback publicly (this means anyone can see your feedback)

Domain	Question item	Comment	Action
	GP?		**online** about your experience of receiving care from a GP?
	D10: When would you be most likely to give feedback online about your experience of receiving care from a GP?	Could one item on the response scale be 'if asked to give feedback by the GP practice'?	Two further scales have now been added with the option to select up to two reasons: • If the GP asked me to leave feedback • If the GP practice asked me to leave feedback
Section G: Other factors that may be affecting patient intention to give feedback about GPs	G1: Do you have a long term condition?	Do you need to give a brief definition of 'long term condition'?	We will explore this in the cognitive interviews with participants and decide then whether a definition is required.
Section H: Socio-demographics	H1: What is your gender?	Under the scale for gender, there should be 'other' for transgender people.	'Other' added on to the scale.

Table 0-2: Summary of amendments made to the second draft questionnaire

Domain	Question item	Comment	Action
Section D: Awareness and consideration of the use of OPF	D7: May I ask, why?	"May I ask" sounds too informal	Question has been revised back to: Why?
	D8a: Which of the following would you prefer to use to leave feedback publicly (this means anyone can see your feedback) online about your experience of receiving care from a GP?	The word online should be before the brackets	Question has been revised to: Which of the following would you prefer to use to leave feedback publicly online (this means anyone can see your feedback) about your experience of receiving care from a GP?
	D9: May I ask, why not?	"May I ask" sounds too informal	Question has been revised back to: Why not?
Section F: Anonymity and privacy	F2a: Would you leave your real name on feedback you leave publicly online?	The final item on the scale was incorrect	The final item on the scale has been revised to: I have no intention of leaving feedback about a GP online
	F4a: Would you mention a GP by name on feedback you leave publicly online?	The final item on the scale was incorrect	The final item on the scale has been revised to: I have no intention of leaving feedback about a GP online
Section G: Other factors that may be affecting patient intention to give feedback about GPs	G1: Do you have a long term condition?	Need to make clear it is a health condition one is asking about	Question revised to: Do you have a long term health condition?
[In multiple domains]	In multiple questions instructions were: "Rank up to three reasons/methods, with 1 being the one you can most relate to"	This instruction had to be changed to match the format of the now online based survey	(You can select up to three reasons/methods, please rank them according to your most preferred)
	The sentence under Section B & Section C	These explanations are not relevant and could be removed.	The explanations have been removed.
	In multiple questions the word "internet" was used	"internet" should be "Internet"	The word "internet" has been changed to "Internet".

Table 0-3: Summary of amendments made to the third draft questionnaire based on the cognitive interviews

Domain	Question item	Comment	Action
Section A: Awareness, history and motivation for giving feedback about GPs (if any)	A4: Have you ever formally given feedback (for example by letter/email/online/feedback form) about the care you have received from a GP?	One participant said: formally given feedback to whom? The question is not clear; there is no context?	Question remains the same, however, the scale has been revised to: • No • Yes, directly to the GP • Yes, directly to the GP surgery • Yes, to a NHS feedback organisation • Yes, to an independent feedback organisation • Yes, other, please specify below: [If No, go to A5. Otherwise, go to B1] (Select all that apply) added as an instruction after the question.
	A5: What are the reasons you have not given feedback about your experience of receiving care from a GP?	Three reasons mentioned by participants that went under "Other" and were repeated by participants should be added on to the scale. Privacy has also been added on.	The following items have been added to the scale: • I cannot be bothered to leave feedback for a GP • I do not know how or where to leave feedback for a GP • I believe GPs do not want patients' feedback • I had concerns about my privacy
	A5: What are the reasons you have not given feedback about your experience of receiving care from a GP?	"I do not want to get the GP into trouble" on the scale should be in the past tense.	Scale item revised to: I did not want to get the GP into trouble
Section B: Consideration of giving feedback about GPs in the future, why and when?	B1: In the near future, if you have an appointment with your GP, would you consider giving feedback about your experience of receiving care from a GP?	'your GP' should be changed to 'a GP' because many patients do not see their own GP.	Question revised to: In the near future, if you have an appointment with a GP, would you consider giving feedback about your experience of receiving care from a GP?
	B3: What are the reasons for you not considering giving feedback about a GP?	The additional items added to the scale of A5 need to be added to the scale for this question too, but in the future sense.	The following items have been added to the scale: • I cannot be bothered to leave feedback for a GP • I do not know how or where to leave feedback for a GP • I believe GPs do not want patients' feedback
Section D: Awareness and consideration of the use of OPF	D2(a): Which specific websites were you aware of? Select all that apply	This question needs 'if any' in the question. One of the items on the scale reads "wasn't" and should be changed to "was not".	Question revised to: Which specific websites were you aware of, if any? Select all that apply "I wasn't aware of" in the scale has been revised to "I was not aware"
	D2(b): How did you become aware?	Although a follow up question, the context needs to be repeated.	Question revised to: How did you become aware of the doctor rating website/s?
	D3: Have you used a doctor rating website to: (please select all that apply)	There should be a "none of the above" item on the scale here. From "C" on the scale, remove "to"	An item added to the scale: D. None of the above "to" removed from item C in the scale.
	D7: Why?	'Why' sounded a bit abrupt	Question revised to: Why would

Domain	Question item	Comment	Action
		during the interviews. Although it is a follow up question, giving more context may be advantageous	you consider using a doctor rating website to give feedback about your experience of receiving care from a GP?
	D8: Which of the following would you prefer to use to leave feedback publicly online (this means anyone can see your feedback) about your experience of receiving care from a GP?	One participant asked whether the app would be free. The explanation in brackets does not add any value to the question.	• The explanation in brackets has been removed from the question, but added to instructions for interviewer • App in the scale has been revised to 'free app'. • 'A web browser on your smartphone' has been added as an item. • An iPad or a digital device available in the waiting area at the GP surgery • A feedback card at the GP surgery which you can write on with a pen (this would then be placed online by the GP surgery)
	D9: Why not?	'Why not' sounded a bit abrupt during the interview. Although it is a follow up question, giving more context may be advantageous Two further reasons have been added to the scale	Question revised to: Why would you not consider using a doctor rating website to give feedback about your experience of receiving care from a GP? The following two items have been added to the scale: • I cannot be bothered to leave feedback for a GP • I believe GPs do not want patients' feedback
	D10: When would you be most likely to give feedback online about your experience of receiving care from a GP?	This question should only be asked if the respondent answered 'Yes' or 'Maybe' to D6	The following instructions have been added next to the question: Display this question only if response to D6 was Yes or Maybe.
Section E: Feedback in public or private	E1(a): Would you like the feedback you and other patients give about your experience of receiving care from a GP to be online, and therefore in the public domain for everyone to see?	Three participants mentioned that yes, if they were able to give the feedback anonymously.	This question has been revised to: Would you like the feedback you and other patients give anonymously about your experience of receiving care from a GP to be online, and therefore in the public domain for everyone to see?
Section F: Anonymity and privacy	F1(a) and F2(a): Would you leave your real name on feedback …?	"real name" was understood differently by participants, some said it was first name, whilst others said it was full name.	Question has been revised to: Would you leave your full name on feedback you give to the GP practice privately?
	F1 (a), F2(a), F3(a) and F4(a)	One respondent said: "yes, if I want a response from the GP". Therefore, there should be "other, please specify" item in the scale.	'Other, please specify below:' has been added to the four scales.
	F2(a), F2(b) ,F4 (a) and F4 (b)	These four questions should only be asked if the respondent answered 'Yes' or 'Maybe' to D6	The following instructions have been added next to the question: Display this question only if response to D6 was Yes or Maybe.
Section G: Other factors that may be affecting patient intention to give	G1) Do you have a long term health condition?	The phrase "long term health condition" was understood by the majority of participants as something	The interviewer will be provided with the following definition of a "long term health condition":

Domain	Question item	Comment	Action
feedback about GPs		you needed to see the doctor regularly for. However, there was disagreement as to for example whether asthma was a long term condition or not.	A Long Term Condition is defined as a condition that cannot, at present be cured; but can be controlled by medication and other therapies. Examples of Long Term Conditions are diabetes, heart disease, chronic obstructive pulmonary disease and asthma (adapted from (Department of Health 2012a)).
Multiple domains	Multiple questions	The phrase 'GP Practice' was used throughout the questionnaire. However, most of the participants (n=7) were more familiar with the phrase 'GP surgery' than 'GP practice'. Data from Google trends also suggested that GP surgery is a phrase used more than GP practice.	'GP Practice' replaced with 'GP surgery' throughout the questionnaire.
	Multiple questions (C1b, C3, D8b, E1b, F1b, F2b, F3b and F4b)	"Please explain your selections/choice" sounds too formal and a phrase that would not normally be used when talking face-to-face.	Advice has been sought from Ipsos MORI as to the best sentence to use in place of these.
	Multiple questions (D10 & B4)	"After both positive and negative experiences" needs to be removed from the scale, because it is not relevant when you can select two options. Selecting up to two options should also be removed; it should be open to however many relevant.	Question instruction revised to: (Select all that apply) "After both positive and negative experiences" has been removed from the scale. "only" removed from the second and third item on the scale.
	Multiple questions (B2, D5, D7)	Add an additional scale to the reasons: patient's desire to expose a mistake or failing of a GP	The following item added on to the scales for: B2: I would want to expose a mistake or failings of the GP. D5: I wanted to expose a mistake or failing of the GP D7: I would like to expose a mistake or failing of the GP
	Multiple questions (A2 and D2a)	One participant said a letter was sent from the NHS; therefore change 'a leaflet from the NHS' to 'Information from the NHS' in the scale.	'A NHS leaflet' in the scale for both questions replaced with 'Information from the NHS'
	Multiple questions	All instructions are not in the same format. For example, the wording in instructions of D2(b) and A2 do not match.	All of the instructions in the questionnaire have been modified to the same format: (Select all that apply) and (You can select up to three reasons, please rank them according to your most preferred).

Table 0-4: Summary of amendments made to the fourth draft questionnaire based on questionnaire expert reviews from reviewers at Ipsos MORI

Domain	Question item	Comment	Action
Section A: Awareness, history and motivation for giving feedback about GPs (if any)	A1: Before this survey, were you aware that you could give feedback about your experience of receiving care from a GP?	The scale needs adapting to include those that assumed that they could give feedback.	Scale revised to: • Yes - I was aware I could give feedback • No - but I assumed I could give feedback • No - I wasn't aware I could give feedback
	A3: Have you ever shared an experience (or story) informally about the care you received from a GP with your family, friends or colleagues?	Question and scale needs to include sharing experiences about family member's care too.	Question and scale revised to: Have you ever shared an experience about the care you or other family members received from a GP with your family, friends or colleagues? • Yes, about myself • Yes, about my partner/spouse • Yes, about my children • Yes, about my parents • Yes, about other family members • No
	A4: Have you ever formally given feedback (for example by letter/email/online/feedback form) about the care you have received from a GP? (Select all that apply)	Question needs to make explicit that you are asking about both positive and negative feedback.	Question revised to: Have you ever formally given positive or negative feedback (for example by letter, email, online, feedback form, etc.) about the care you have received from a GP?
Section B: Consideration of giving feedback about GPs in the future, why and when?	B1: In the near future, if you have an appointment with a GP, would you consider giving feedback about your experience of receiving care from a GP?	Make question specific to GPs based at the local surgery, instead of including those GPs based in secondary care, or at out of hours surgery for example.	Question revised to: Would you consider giving feedback about your experience of receiving care from a GP based in your surgery/local health centre in the future?
	B2 & B3: What are the reasons for you considering/ not considering giving feedback about a GP?	There are two issues here, the first is that you are asking them to speculate about an emotive event that hasn't happened - so the answers are very unlikely to replicate the true proportions. The second is that you would need to ask it as an open-ended or an unprompted response list - but at this stage in the questionnaire they have no guidance as to what we want from them and they have no way of making that leap about an event in the future	Questions B2 & B3 were removed from the questionnaire. A set of statement questions were added to Section G (G4) in place of these, with an agreement scale. The set of statements are: 1.I would want someone to improve the service so that it can be better for the next patient 2.I believe other people could benefit from knowing about my experience 3.I am concerned leaving feedback will impact my relationship with a GP 4.I believe leaving feedback for GPs will make no difference 5.I would be concerned about my privacy when leaving feedback for my GP on paper 6.I would be concerned about my privacy when leaving feedback for my GP online 7.I believe GPs do not want patients' feedback 8.I do not know how or where to leave feedback for a GP 9.I would want to alert people to the mistakes or failings of the GP. 10.I would like to read about other

Domain	Question item	Comment	Action
			peoples' experiences with a GP 11.I believe I would find it easier to give feedback online rather than using other methods to give feedback
	B4: When would you be most likely to give feedback about your experience of receiving care from a GP?	This question needs revising.	The question was revised to: To what extent are you more or less likely to give feedback about your experience of receiving care from a GP in your surgery/local health centre if the experience was positive or negative, or would it make no difference either way? Would you be…?
	[New question added]	A new question was proposed by the reviewers.	The following new question was added: To what extent are you likely or unlikely to give feedback about your experience of receiving care from a GP in your surgery/local health centre in the following circumstances? 1.Give unprompted feedback about your experience directly to the GP 2.Give feedback about your experience if a GP in your surgery/local health centre asked you to. 3. Give feedback about your experience if your GP surgery/local health centre asked you to.
Section C: Preference on mode of feedback	C1 & C2	Both questions can be combined together into one question	Question revised to: In which of the following ways, if any, would you prefer to give [INSERT POSITIVE/NEGATIVE] feedback about a GP? Please choose up to three. And which would be your preferred way? STATEMENTS - ROTATE ORDER 1. Positive feedback 2. Negative feedback
Section D: Awareness and consideration of the use of OPF	D3: Have you used a doctor rating website to …	Question needs revising. The scale needs to make clear whether the GP was a GP at the patient's local surgery or elsewhere.	Question revised to: For which of the following reasons, if any, have you used a doctor rating website? The following item was also added to the scale: 5.To give feedback about your experience of receiving care from a GP in another surgery/local healthcare centre
	D4: Would you say the majority of feedback you left on this website for a GP or GPs was:	The question should be revised to asking about the last time they left feedback, and then used as a filter for the next question	Question revised to: Thinking about the last time you gave feedback about a GP on a doctor rating website, on reflection, was the feedback largely positive, largely negative or was it equally positive and negative?
	D8a: Which of the following would you prefer to use to leave feedback publicly online* about your experience of receiving care from a GP?	Question needs revising.	Question revised to: If you were to give feedback about a GP in your surgery/local health centre on a doctor rating website, which of the following methods, if any, would use? And which is your preferred

Domain	Question item	Comment	Action
			method?
	D10: When would you be most likely to give feedback online about your experience of receiving care from a GP?	Conjecture, this would be too difficult for respondents to give an accurate account of their future behaviour - it needs tackling in a different way and we have approached that at the beginning of the survey	This question has been removed.
Section E: Feedback in public or private	E1a: Would you like the feedback you and other patients give anonymously about your experience of receiving care from a GP to be online, and therefore in the public domain for everyone to see?	Question needs revising.	Question revised to: If you were to give feedback about your experience of the care received from a GP, would you like this feedback to be online so other people could read about your experience and/or you could read about other people's experience of the care received from a GP? This feedback could still be given anonymously.
Section F: Anonymity and privacy	F1a, F2a, F3a, F4a	These questions can be combined together in an alternative format as one main question	Question has been revised to: I'm now going to show you a list of things people may choose to do when giving feedback for a GP in their surgery/local health centre. For each one I'd like you to tell me in which situation, if any, you would choose to do each one.
	F1b, F2b, F3b, F4b	This isn't suitable within this framework - you can ask open questions but if we consistently ask respondents to validate and evaluate their responses they will become fatigued, their responses are likely to move further away from the true answers and they are likely to acquiesce more, among other things	These sub-questions have been removed.
Section H: Socio-demographics	All questions	Ipsos MORI already collect standard demographic data free of charge, so the questions in the section can be replaced by them.	The questions in this section were replaced by Ipsos MORI standard demographic questions.
Multiple domains	Questions A5, D7, D9	The scales can be leading and it leads subsequent questions. It is better to ask as an open-ended and code back to code frame.	These questions will be asked as unprompted open ended questions.
All domains	All question reference numbers and filters	The question reference numbers are currently in "Section, Number" format. These need revising to match the Ipsos MORI format. The filters on questions need revising to match the Ipsos MORI required format.	All questions' reference numbers were revised to match the Ipsos MORI questionnaire format, although the original question numbers remained in brackets for reference. The filtering as required by Ipsos MORI was also added.

Table 0-5: Summary of amendments made to the fifth draft questionnaire based on pilot testing

Domain	Question item	Comment	Action
Section A: Awareness, history and motivation for giving feedback about GPs (if any)	A3: Have you ever shared an experience about the care you or other family members received from a GP with your family, friends or colleagues?	Everyone responded yes to this question, therefore this question was deemed as not essential.	Therefore this question was removed, so that another essential question could be asked in place of it. Additional statements were added to G4.
Section B: Consideration of giving feedback about GPs in the future, why and when?	B4: To what extent are you more or less likely to give feedback about your experience of receiving care from a GP in your surgery/local health centre if the experience was positive or negative, or would it make no difference either way? Would you be…?	Question needs to clarify that it is about a GP based in the surgery, to avoid misinterpretation.	Question amended to: To what extent are you more or less likely to give feedback about your experience of receiving care from a GP based in your surgery/local health centre if the experience was positive or negative, or would it make no difference either way? Would you be…?
Section C: Preference on mode of feedback	C1&C2: In which of the following ways, if any, would you prefer to give [INSERT POSITIVE/NEGATIVE] feedback about a GP? Please choose up to three. And which would be your preferred way?	The column titles were: Positive feedback and Negative feedback. --- In the scale, writing a letter and emailing are different; therefore they need to be separated. --- In the scale, items 9 and 10 about NHS website and independent website did not make clear that the public would then be able to see the feedback left on there. --- It was not clear whether the app would publish the feedback online or give it to the GP practice privately.	This was changed to: Feedback about a positive experience and Feedback about a negative experience. --- Email and letter were split into two separate items on the scale. --- Items 9 and 10 on the scale had the following added on to them: (and everyone can then read the feedback) --- The single item on the scale about an app was replaced with two items: • Give feedback through an app on your smartphone directly to the GP surgery/local health centre • Give feedback through an app on your smartphone, which is then published to an NHS/Independent website
Section D: Awareness and consideration of the use of OPF	D8a: If you were to give feedback about a GP in your surgery/local health centre on a doctor rating website, which of the following methods, if any, would use?	One item on the scale requires modification. Replace 'this' with 'the feedback'.	The item on the scale was amended to: A feedback card at your GP surgery which you can write on (the feedback would then be placed online by your GP surgery)
	D7: Why would you consider using a doctor rating website to give feedback about your experience of receiving care from a GP?	'To give feedback' in the question needs to be emphasised, so the question is not misinterpreted.	'To give feedback' in the question was underlined.
	D9: Why wouldn't you use a doctor rating website to give feedback about your experience of receiving care from a GP?	Instructions need to be added to ensure that the interviewers prompt for open ended question --- 'To give feedback' in the question needs to be	Instructions added: INTERVIEWER PROBE FULLY: What other reasons? --- 'To give feedback' in the question was underlined.

Domain	Question item	Comment	Action
		emphasised, so the question is not misinterpreted.	
Section E: Feedback in public or private	E1 (a): If you were to give feedback about your experience of the care received from a GP, would you like this feedback to be online so other people could read about your experience and/or you could read about other people's experience of the care received from a GP? This feedback could still be given anonymously.	The responses to E1(a) and E1(b) were a repetition of responses to previous questions. E1(a) was also problematic because it contained two questions within one question.	Therefore, both of these questions (and hence Section E) were removed entirely from the questionnaire. However, the following statement was added to G4: I believe I would benefit from reading about other peoples' experiences with a GP
Section F: Anonymity and privacy	F1a, F2a, F3a, F4a	One of the statements had a spelling mistake in it, and an additional item on scale needs to be added for those that would not give feedback.	One statement corrected to: "Give your full name on feedback you leave on a doctor rating website" And one additional item on scale added: "I would not give feedback about a GP using this method"
Section G: Other factors that may be affecting patient intention to give feedback about GPs	G4: I'm now going to show you some statements about leaving feedback for GPs. Please tell me to what extent you agree or disagree with each one.	Major amendments were made to the statements in this question based on results of the pilot testing. Some statements were edited, others were added on.	The following statements were added on: • I would consider leaving feedback about a GP on social media (such as Facebook or Twitter) • I would prefer to leave feedback for a GP online on a doctor rating website rather than leave it on a feedback card at the GP surgery/health centre • I believe sharing my experience of receiving care from a GP online on a doctor rating website would make me feel better • I believe sharing my experience online on a doctor rating website would be taken more seriously by the GP or the GP practice • Giving/leaving feedback about a GP is something I have thought about before • I believe I would benefit from reading about other peoples' experiences with a GP
Other (introduction)	**N/A**	There was a need to highlight in the introduction of the questionnaire that feedback refers to both negative and positive experiences.	Therefore, the following sentence was added to the introduction: This feedback could be positive or negative.

Table 0-6: Summary of amendments made to the sixth draft questionnaire based on the final expert review

Domain	Question item	Comment	Action
Section A: Awareness, history and motivation for giving feedback about GPs (if any)	A1: Before this survey, were you aware that you could give feedback about your experience of receiving care from a GP?	Suggests question is amended to: Before this survey, to what extent, if at all, were you aware that you could give feedback about your experience of receiving care from a GP?	Question amended as suggested.
	A2: In which of the following ways, if any, did you become aware that you could leave feedback about your experience of receiving care from a GP?	'Leave' in the question suggests that they leave it at the surgery, whereas they could give it later on when at home, and it needs to be consistent with A1. ---------- Poster should be added to the following item on the scale: I read /saw a letter/leaflet/pamphlet about it from the NHS	Question amended to: In which of the following ways, if any, did you become aware that you could give feedback about your experience of receiving care from a GP? ---------- Poster was added on after pamphlet.
Section C: Preference on mode of feedback	C1&C2: In which of the following ways, if any, would you prefer to give [INSERT POSITIVE/NEGATIVE] feedback about a GP? Please choose up to three. And which would be your preferred way?	The items on the scale that reference NHS website and independent website, it needs to be clear whether the feedback can be left anonymously or not.	"(this could be anonymous or not)" was added to the following items on the scale: 7,8,9,10,11,12
Section D: Awareness and consideration of the use of OPF	D1: Before this survey, were you aware of doctor rating websites?	Suggests question is amended to: Before this survey, were you aware, or not, of doctor rating websites?	Question amended as suggested.
	D2b: In which of the following ways, if any, did you become aware of doctor rating websites?	Poster should be added to the following item on the scale: I read /saw a letter/leaflet/pamphlet about it from the NHS	Poster added on after pamphlet.
	D3: Have you ever used a doctor rating website?	Suggests question is amended to: Have you ever used a doctor rating website, or not?	Question amended as suggested.
	D4: Thinking about the last time you left feedback for a GP on a doctors rating website, which, if any, of these reasons motivated you to leave feedback about that GP?	Largely should be changed to 'mainly' in the question. --------- The Showcard is a really long list. Could it be grouped under headings?	Largely replaced with mainly in the question and scale. ---------- The following headings were placed on the Showcard: experience, sharing the experience, specific issue, to get a response, so it would be taken seriously, negative experience, and other.
	D6: Would you consider using a doctor rating website in the future?	Suggests question is amended to: To what extent if at all, would you consider using a doctor rating website in the future?	Question amended as suggested.
Section G: Other factors that may be affecting patient intention to give	G4: I'm now going to show you some statements about leaving feedback for GPs. Please tell me to what extent	The 'I believe' on statements in this question is not required. It sounds very repetitive.	'I believe' was removed from 7 statements in this question.

Domain	Question item	Comment	Action
feedback about GPs	you agree or disagree with each one.		
	G1: Do you have a long term health condition? A long term health condition can be described as a condition that cannot be cured, at present, but can be controlled by medication or other therapies. Long term health conditions include conditions such as diabetes, heart disease, high blood pressure, emphysema, asthma, arthritis, depression, dementia, etc.	The wording as it is reads in this question suggests that you have to have one of the conditions listed to have a chronic illness. It needs to say something like 'but are not limited to'	Question amended to: Do you have a long term health condition? A long term health condition can be described as a condition that cannot be cured, at present, but can be controlled by medication or other therapies. Long term health conditions include (but are not limited to) conditions such as diabetes, heart disease, high blood pressure, emphysema, asthma, arthritis, depression, dementia, etc.

iv) Final questionnaire (implemented in Study C)

FINAL QUESTIONNAIRE

Key to codes used in instructions
SINGLE CODE: Allow one response only
MULTI CODE: Allow multiple responses
ALLOW DK: Allow don't know (a hidden response – as not sure). Refused is coded as **REF** (it very rarely happens)
RAN LIST: randomise the order, to reduce order bias
FIX CODES: similar items so keep these items to together
OPEN ENDED: An open ended question.
ASK ALL: Question asked to all participants, not filtered.

New Screen
INTERVIEWER: PLEASE SHOW SCREEN UNTIL OTHERWISE INSTRUCTED
DP: please underline SHOW, showscreen

In this part of the survey, you will be asked about how and why you may like to or not like to give feedback about a GP. Feedback refers to reviews, rating, comments, and complaints. This feedback could be positive or negative.

Where there is reference to "GP" in this survey, it means general practitioner. This is the doctor you see when you visit a GP surgery or local health centre.

All of the questions in this part of the survey refer to giving feedback about your experience of receiving care from GPs only and not any other healthcare professional.

New Screen

SECTION A - Awareness, history and motivation for giving feedback to GPs (if any)

ASK ALL
TY01. **(A1)** Before this survey, to what extent, if at all, were you aware that you could give feedback about your experience of receiving care from a GP?
SINGLE CODE, ALLOW DK

1. Yes - I was aware I could give feedback
2. No - but I assumed I could give feedback
3. No - I wasn't aware I could give feedback

IF TY01'1', THEN ASK TY02
ALL WHO ARE AWARE THEY COULD GIVE FEEDBACK
TY02. **(A2)** In which of the following ways, if any, did you become aware that you could give feedback about your experience of receiving care from a GP?
ALLOW DK

1. I was informed about it by a GP
2. I was informed about it by another healthcare professional
3. I was informed about it by a receptionist at a GP surgery/health centre
4. I read /saw a letter/leaflet/pamphlet/poster about it from the NHS
5. I read/saw some information about it on the NHS website
6. I read/saw information about it elsewhere on the internet
7. I read/saw/heard an advert about it
8. I saw it on a TV programme
9. A friend, family member or colleague informed me
10. Other (specify)

ASK ALL
TY03. **(A3)** Have you ever formally given positive or negative feedback (for example by letter, email, online, feedback form, etc.) about the care you have received from a GP?
SINGLE CODE '1', MULTI CODE '2-11', ALLOW DK

1. No
2. Yes - to a GP in my surgery/local health centre
3. Yes - to my GP surgery/local health centre
4. Yes - to a GP in another surgery/health centre
5. Yes - to another GP surgery/health centre
6. Yes - to another part of the NHS
7. Yes - through PALS (Patient Advice and Liaison Services)
8. Yes - to the Care Quality Commission
9. Yes - to an independent organisation working on behalf of the NHS to collect feedback
10. Yes - to an independent organisation able to collect feedback about a GP
11. Yes - other (specify)

IF TY03'1', THEN ASK TY04
ALL WHO HAVE NEVER FORMALLY GIVEN FEEDBACK
TY04. **(A5)** Why haven't you given feedback about your experience of receiving care from a GP?
INTERVIEWER PROBE: WHAT OTHER REASONS? WHAT OTHER REASONS?
OPEN END, ALLOW DK

SECTION B - Consideration of giving feedback to GPs in the future, why and when?

NEW SCREEN
The next few questions are about giving feedback about your experience of receiving care from **a GP in your surgery/local health centre.**

NEW SCREEN
ASK ALL
TY05. **(B1)** To what extent, if at all, would you consider giving feedback about your experience of receiving care from a GP based in your surgery/local health centre in the future?
SINGLE CODE, ALLOW DK FORWARD AND REVERSE

1. Yes - definitely
2. Yes - possibly
3. No

ASK ALL
TY06. **(B4)** To what extent are you more or less likely to give feedback about your experience of receiving care from a GP based in your surgery/local health centre if the experience was positive or negative, or would it make no difference either way? Would you be…?
SINGLE CODE, FORWARD AND REVERSE, FIX CODE 6 TO BOTTOM, ALLOW DK

1. A lot more likely to give feedback if your experience was negative
2. A little more likely to give feedback if your experience was negative
3. It would make no difference if the feedback was positive or negative
4. A little more likely to give feedback if your experience was positive
5. A lot more likely to give feedback if your experience was positive
6. I would not give feedback

ASK ALL
TY07. **(B5)** How likely or unlikely are you to do each of the following things?

SINGLE CODE, FORWARD AND REVERSE, FIX DON'T KNOW TO BOTTOM ALLOW DK

1. Very likely
2. Fairly likely
3. Neither likely nor unlikely
4. Fairly unlikely
5. Very unlikely

RAN ORDER OF STATEMENTS

1. Give unprompted feedback about your experience directly to the GP
2. Give feedback about your experience if a GP in your surgery/local health centre asked you to.
3. Give feedback about your experience if your GP surgery/local health centre asked you to.

SECTION C - Preference on mode of feedback

IF TY05'1 or 2' OR TY06'1-5'OR TY07'1-3' at COL 123, THEN ASK TY08
ALL WHO WOULD CONSIDER GIVING FEEDBACK
TY08. **(C1&C2)** In which of the following ways, if any, would you prefer to give [INSERT POSITIVE/NEGATIVE] feedback about a GP? Please choose up to three. And which would be your preferred way?

STATEMENTS - ROTATE ORDER

1. Feedback about a positive experience
2. Feedback about a negative experience

COLS- MULTI CODE COL 1 AND ALLOW MAX 3, SINGLE CODE 17, ALLOW DK AND SINGLE CODE COL 2 ALLOW DK

1. Top 3
2. Main preference

ROWS-

1. Give feedback directly to the GP (either in person or by Telephone)
2. Write a letter directly to the GP
3. Send an email directly to the GP
4. Give feedback to your GP surgery/local health centre manager (either in person or by Telephone)
5. Write a letter to your GP surgery/local health centre's manager
6. Send an email to your GP surgery/local health centre's manager
7. Fill in a feedback form at your GP surgery/local health centre (this could be anonymous or not)
8. Fill in a feedback form on the GP surgery/local health centre's website (this could be anonymous or not)
9. Post feedback on an NHS website that publishes feedback for GPs (and everyone can then read the feedback) (this could be anonymous or not)
10. Post feedback on an independent website that publishes feedback for GPs (and everyone can then read the feedback) (this could be anonymous or not)
11. Give feedback through an app on your smartphone directly to the GP surgery/local health centre (this could be anonymous or not)
12. Give feedback through an app on your smartphone, which is then published to an NHS/Independent website (this could be anonymous or not)
13. Give feedback through PALS (Patient Advice and Liaison Services)
14. Contact the Care Quality Commission
15. Give feedback on social media such as Facebook, Twitter, etc.
16. Other(specify)
17. I would not give feedback for a GP

MATCH ORDER OF ASKING TY09A AND TY09B AS TY08.
IF TY08 1_'1/16' THEN ASK TY09A

ALL WHO WERE ABLE TO SAY HOW THEY WOULD PREFER TO GIVE POSITIVE FEEDBACK
TY09A. (C1(b) & C3) You said you would prefer to give POSITIVE feedback in the following ways: [INSERT CODES AT TY08_1]. Why do you say that?

INTERVIEWER PROBE: WHAT OTHER REASONS? WHAT OTHER REASONS
OPEN-ENDED, ALLOW DK

IF TY08 2_'1/16' THEN ASK TY09B
ALL WHO WERE ABLE TO SAY HOW THEY WOULD PREFER TO GIVE NEGATIVE FEEDBACK
TY09B. You said you would prefer to give NEGATIVE feedback in the following ways: [INSERT CODE AT TY08_2]. Why do you say that?

INTERVIEWER PROBE: WHAT OTHER REASONS? WHAT OTHER REASONS
OPEN-ENDED, ALLOW DK

Section D - Awareness and consideration of the use of online patient feedback

NEW SCREEN
ASK ALL
The next section asks about doctor rating websites. These are websites which you can use to search for health services in your local area or other areas and where patients and carers can leave anonymous feedback about their experience of using health services or receiving care from health care professionals, including doctors and GPs.

The feedback is published on the website, so people accessing the website can read and compare the reviews of the health services in their local area, or other areas.

ASK ALL
TY10. (D1) Before this survey, were you aware, or not, of doctor rating websites?
SINGLE CODE, ALLOW DK

1. Yes
2. No

IF TY10 '1', THEN ASK TY11
ALL WHO ARE AWARE OF DOCTOR RATINGS WEBSITES
TY11. (D2a) Which, if any, of the following doctor rating websites are you aware of?
MULTI CODE 1-5 RAN CODES 1-5, SINGLE CODE 6 FIX TO BOTTOM, ALLOW DK

1. www.nhs.uk/service-search
2. www.iwantgreatcare.org
3. www.patientopinion.co.uk
4. www.privatehealth.co.uk
5. Other (specify)
6. I am not aware of any specific doctor rating websites.

IF TY10 '1', THEN ASK TY12
ALL WHO ARE AWARE OF DOCTOR RATINGS WEBSITES
TY12. (D2b) In which of the following ways, if any, did you become aware of doctor rating websites?
And how did you first become aware?
GRID
COLS

1. Aware MULTI CODE, RAN LIST, FIX CODES 1-3 TOGETHER AND FIX CODE 5 AND 6 TOGETHER
2. First become aware SINGLE CODE, ORDER AS COL 1, FIX CODES 1-3 TOGETHER AND FIX CODE 5 AND 6 TOGETHER

ROWS ALLOW DK

1. I was informed about it by a GP
2. I was informed about it by another healthcare professional
3. I was informed about it by a receptionist at a GP surgery/health centre
4. I read /saw a letter/leaflet/pamphlet/poster about it from the NHS
5. I read/saw some information about it on the NHS website
6. I read/saw information about it elsewhere on the internet
7. I read/saw/heard an advert about it
8. I saw it on a TV programme
9. A friend, family member or colleague informed me
10. Other (specify)

IF TY10'1' THEN ASK TY13
ALL WHO ARE AWARE OF DOCTOR RATING WEBSITES
TY13. (D3) Have you ever used a doctor rating website, or not?
SINGLE CODE, ALLOW DK

1. Yes
2. No

IF TY13 '1', THEN ASK TY14
ALL WHO HAVE USED A DOCTOR RATING WEBSITES
TY14. (D3b) For which of the following reasons, if any, have you used a doctor rating website?
MULTI CODE, FIX CODES 4-5 TOGETHER, RAN, ALLOW DK /NONE OF THESE

1. To find a GP/doctor/consultant/hospital
2. To read GP/doctor/consultant/hospital reviews/ratings
3. To give feedback or review your experience of **the NHS**
4. To give feedback about your experience of receiving care **from a GP** in your surgery/local healthcare centre

5. To give feedback about your experience of receiving care **from a GP** in another surgery/local healthcare centre
6. Other (specify)

SHOWCARD TY15
IF TY14'4 or 5', THEN ASK TY15
ALL WHO HAVE LEFT FEEDBACK FOR A GP ON A DOCTOR RATING WEBSITE
TY15. (D5) Thinking about the last time you left feedback for a GP on a doctors rating website, which, if any, of these reasons motivated you to leave feedback about that GP?
MULTI CODE, ALLOW DK

SHOWCARD

Experience
1. I wanted to let the GP know how I much appreciated the consultation
2. I wanted to let the GP know that I appreciated the quality of their service in general
3. The reception or admin staff were really helpful
4. It was easy to get an appointment
5. The service was much better than what I'm used to/have experienced in the past

Sharing the experience
6. I believe sharing my experience would benefit the GP
7. I wanted to share my experience with other people
8. I thought other people could benefit from knowing about my experience
9. I wanted to ask other people's advice about my experience
10. I believe sharing my experience would make me feel better
11. I wanted to know if other people's experiences with the GP were the same as mine
12. I wanted to alert people to the mistakes or failings of the GP

Specific issue
13. I wanted to comment on my treatment or the service in general
14. I wanted to comment on a specific consultation

To get a response
15. I wanted to prompt the local health authority to respond to a complaint I had
16. I wanted to improve the service received from the GP

So it would be taken seriously
17. I believed the GP would take my experience more seriously if I shared it online
18. I believed the GP Surgery/local health centre would take my experience more seriously if I shared it online

Negative experience
19. I didn't like the attitude of the GP
20. I didn't like the attitude of the General Practice Nurse I saw
21. I didn't like the attitude of the reception or admin staff
22. I couldn't get an appointment
23. I couldn't see a doctor during the appointment
24. I have problems using the surgery's systems

Other
25. Other specify

IF TY14'4 or 5', THEN ASK TY16
ALL WHO HAVE LEFT FEEDBACK FOR A GP ON A DOCTOR RATING WEBSITE
TY16. (D4) Thinking about the last time you gave feedback about a GP on a doctor rating website, was the feedback mainly positive, mainly negative or was it equally positive and negative?
SINGLE CODE, ROT, ALLOW DK

1. Mainly positive
2. Mainly negative
3. Equally positive and negative

ASK ALL
TY17. (D6) To what extent if at all, would you consider using a doctor rating website in the future?
SINGLE CODE, FORWARD AND REVERSE

1. Yes - definitely
2. Yes - possibly
3. No

ASK ALL
TY18. (D6a) For which of the following reasons, if any, would you consider using a doctor rating website?
MULTI CODE, FIX CODES 4-5 TOGETHER, RAN, ALLOW DK

1. To find a GP/doctor/consultant/hospital
2. To read GP/doctor/consultant/hospital reviews/ratings
3. To give feedback or review your experience of **the NHS**
4. To give feedback about your experience of receiving care **from a GP** in your surgery/local healthcare centre
5. To give feedback about your experience of receiving care **from a GP** in another surgery/local healthcare centre
6. Other (specify)
7. I would not use a doctor rating website for any reason

New Screen
INTERVIEWER: PLEASE DO NOT SHOW SCREEN UNTIL OTHERWISE INSTRUCTED
DP: please underline SHOW, showscreen

IF NOT TY18'4 or 5', THEN ASK TY19
ALL WHO WOULD NOT USE A DOCTOR RATING WEBSITE TO LEAVE FEEDBACK ABOUT A GP
TY19. (D9) Why wouldn't you use a doctor rating website **to give feedback** about your experience of receiving care from a GP?

INTERVIEWER PROBE FULLY: What other reasons?
ALLOW DK
OPEN-ENDED

IF TY18'4 or 5', THEN ASK TY20

TY20. (D7) Why would you consider using a doctor rating website **to give feedback** about your experience of receiving care from a GP?
INTERVIEWER: PROBE FULLY. What other reasons?
ALLOW DK
OPEN ENDED

New Screen
INTERVIEWER: PLEASE SHOW SCREEN UNTIL OTHERWISE INSTRUCTED
DP: please underline SHOW, showscreen

IF TY18'4 or 5', THEN ASK TY21
ALL WHO WOULD GIVE FEEDBACK ON A DOCTOR RATING WEBSITE

TY21. (D8a) If you were to give feedback about a GP in your surgery/local health centre on a doctor rating website, which of the following methods, if any, would you use?

And which is your preferred method?

GRID - COLS, MULTI CODE COL 1, SINGLE CODE COL 2
MASK LIST AT COL 2 - ONLY SHOW RESPONSES IN COL 1

1. Method(s) would use
2. Preferred method

ROWS - MULTI CODE, RAN, FIX OTHER TO BOTTOM, ALLOW DK

1. A computer/laptop which you have ready access to
2. A free app on your smartphone/other device
3. A web browser on your smartphone
4. An iPad or digital device available in the waiting area at your GP surgery
5. A feedback card at your GP surgery which you can write on (the feedback would then be placed online by your GP surgery)
6. Other (specify)

IF TY21_2'1/6' THEN ASK TY22
New Screen
INTERVIEWER: PLEASE DO NOT SHOW SCREEN UNTIL OTHERWISE INSTRUCTED
DP: please underline SHOW, showscreen

TY22. (D8b) You said that you would prefer to leave feedback on a doctor rating website, using [INSERT ANSWER AT TY21 COL2]. Why is this your preferred method?
INTERVIEWER: PROBE FULLY. What other reasons?
ALLOW DK

1. Easy to use
2. Convenient
3. Quicker- feedback appears online immediately
4. Can provide feedback at the time of the issue
5. Can provide feedback later
6. Can provide feedback at any time
7. Don't have access to the internet/computer/mobile phone
8. Don't know how to use internet/apps/ipads
9. Don't trust the GP surgery to add my feedback online
10. Concerns about anonymity if provide feedback on paper
11. Prefer to use my own device- don't trust NHS IT systems
12. Other specify

SECTION F - Anonymity and privacy

IF TY05'1 or 2' OR TY17'1 or 2', THEN ASK TY23
ASK ALL WHO WOULD CONSIDER GIVING FEEDBACK

TY23. (F1a & F2a & F3a & F4a) I'm now going to show you a list of things people may choose to do when giving feedback for a GP in their surgery/local health centre. For each one I'd like you to tell me in which situation, if any, you would choose to do each one.
STATEMENTS:
SHOW STATEMENTS 1&3 IF TY05'1 or 2'; SHOW STATEMENTS 2&4 IF TY17'1 or 2'

1. Give your full name on feedback you give directly to your GP surgery/local health centre
2. Give your full name on feedback you leave on a doctor rating website
3. Mention a GP by name on feedback you give to your GP surgery/local health centre
4. Mention a GP by name on feedback you leave on a doctor rating website

MULTI CODE 1-3, SINGLE CODE 4-5, ROT CODES 1-2, ALLOW DK

1. When giving feedback about positive experiences
2. When giving feedback about negative experiences
3. Other (specify)
4. I would not do this
5. I would not give feedback about a GP using this method

SECTION G - Other factors that may be affecting patient intention to give feedback to GPs

ASK ALL

TY24. (G4) I'm now going to show you some statements **about leaving feedback for GPs**. Please tell me to what extent you agree or disagree with each one.
RANDOMISE ORDER OF STATEMENTS

STATEMENTS

1. Giving/leaving feedback about a GP is something I have thought about before
2. I would leave feedback because I want someone to improve the service so that it can be better for the next patient
3. Other people could benefit from knowing about my experience of care from a GP
4. I am concerned that leaving feedback with my full name on it will impact my relationship with a GP
5. Leaving feedback for GPs will make no difference
6. I would be concerned about my privacy when leaving feedback for a GP on a feedback form at the GP surgery/health centre
7. I would be concerned about my privacy when leaving feedback for a GP online on a doctor rating website
8. GPs do not want patients' feedback
9. I do not know how or where to leave feedback for a GP
10. I would benefit from reading about other peoples' experiences of receiving care from a GP
11. I would find it easier to give feedback online on a doctor rating website rather than giving it on a feedback form at the GP surgery/health centre
12. I would consider leaving feedback about a GP on social media (such as Facebook or Twitter)
13. I would prefer to leave feedback for a GP online on a doctor rating website rather than leave it on a feedback card at the GP surgery/health centre
14. Sharing my experience of receiving care from a GP online on a doctor rating website would make me feel better
15. Sharing my experience online on a doctor rating website would be taken more seriously by the GP or the GP practice

SINGLE CODE, FORWARD AND REVERSE, ALLOW DK

1. Strongly agree
2. Tend to agree
3. Neither agree nor disagree
4. Tend to disagree
5. Strongly disagree

ASK ALL

TY25. (G3) Approximately how many GPs are there in your current GP surgery/ local health centre?

SINGLE CODE, ALLOW DK

1. 1 GP
2. 2-3 GPs
3. 4-5 GPs
4. 6-9 GPs
5. More than 10 GPs

ASK ALL

TY25. (G2) Have you ever used the Internet to search for health information?

SINGLE CODE, ALLOW DK

1. Yes
2. No

ASK ALL

TY27. (G1) Do you have a long term health condition? A long term health condition can be described as a condition that cannot be cured, at present, but can be controlled by medication or other therapies. Long term health conditions include (but are not limited to) conditions such as diabetes, heart disease, high blood pressure, emphysema, asthma, arthritis, depression, dementia, etc.

SINGLE CODE

1. Yes
2. No
3. Don't Know
4. Prefer not to say

SECTION H - Socio-demographics

ASK ALL (These standard demographic questions below were devised by IPSOS Mori are asked to all participants)

Question REGION

Standard region (from sample point)

1. North
2. North-West
3. Yorks & Humberside
4. West Midlands
5. East Midlands
6. East Anglia
7. South West
8. South East
9. Greater London
10. Wales
11. Scotland

Question SEX

Sex of respondent

1. Male
2. Female

Question AGE Numeric.
AGE OF RESPONDENT: Enter exact age

<OPEN ENDED>
Refused

Question QUAL
Using this card, please tell me which, if any, is the highest educational or professional qualification you have obtained. Just read out the letter or letters which apply.
(IF STILL STUDYING, CHECK FOR HIGHEST ACHIEVED SO FAR)

1. A GCSE/O-Level/CSE
2. B Vocational qualifications (=NVQ1+2)
3. C A-Level or equivalent (=NVQ3)
4. D Bachelor Degree or equivalent (=NVQ4)
5. E Masters/PhD or equivalent
6. F Other
7. G No formal qualifications
8. H Still studying
   Don't Know

Question CIEWORKSTATUS
Could you please tell me which of these applies to the chief income earner?

1. Have paid job - Full time (30+ hours per week)
2. Have paid job - Part time (8-29 hours per week)
3. Have paid job - Part time (Under 8 hours per week)
4. Not working - Housewife
5. Self-employed
6. Full time student
7. Still at school
8. Unemployed and seeking work
9. Retired
10. Not in paid work for other reason
11. Not in paid work because of long term illness or disability

Refused

Question SOCG
WORK STATUS : %SOCTX%
DETAILS OF CIE: %COPIED%
CODE IN SOCIAL GRADE:

1. A
2. B
3. C1
4. C2
5. D
6. E

HH-DURA Question
Which, if any, of these items are there in your household?
PROBE: Which others? INTERVIEWER: MOBILE PHONE DOES NOT INCLUDE CAR PHONE.
DURABLES
Entertainment
D. A smart/connected TV set that is connected to the internet (a TV set that is connected directly to the internet and not through another device such as a games console, computer or set top box)
L. A 3D (3 dimensional) TV set (a TV that allows you to watch movies and TV shows in 3D, as long as you are wearing special 3D glasses when you watch it)
P. An HDTV set (TV can receive High Definition television that has a significantly higher resolution than traditional formats)
G . Any Other TV
V. DVD player / Blu-ray player
N. Satellite or Cable Subscription (i.e. a monthly subscription you pay to watch extra channels)
U. Freeview or Freesat (i.e. digital TV programmes accessed through a set-top box or satellite dish, that you do not have to pay a subscription for)H. Personal Video Recorder (PVR) / DTR - e.g. Sky+ / V+ / Freeview+ / an in-built hard-drive on your TV or set-top box
Q. Last generation games console (NOT home computer) (e.g. Wii, PS3, Xbox 360)
A. Next generation games console (NOT home computer) (e.g. Wii U, PS4, Xbox One)
X. A handheld games console (e.g. Nintendo DS, PS Vita)
F. MP3 Player (e.g. Apple Ipod or Sony Walkman)
K. Other Games console
Miscellaneous
R. Personal Computer / Desktop PC (PC, Mac or other type of home computer)
B. Laptop (PC/Apple, including netbooks)
S. A tablet (e.g. an iPad, Samsung Galaxy Tab or Amazon Kindle Fire)
I. An eBook reader (e.g. Amazon Kindle/Sony Reader)
E. Simple/feature mobile phone (a phone with simple features and limited media / internet functions)
W. Smart phone (e.g. iPhone, Blackberry, Android, Windows)
M. Telephone (landline, i.e. NOT a mobile phone)
Cards
O. Debit card/s (e.g. Maestro, Visa Debit Card)
T. Credit card/s (e.g. Visa Credit Card, Mastercard, American Express)
C. Storecard (A card that can typically on be used to buy items or services in one brand of stores)
J. Loyalty card - (A card that typically provides discounts or rewards within store)
Refused
Don't know
None of these

Question NETFQ
Which of these best describes your use of the internet? Please include all use of the internet, including sending and receiving emails

1. Several times a day
2. Around once a day
3. 4 or 5 times a week
4. 2 or 3 times a week
5. Around once a week
6. 2 or 3 times a month
7. Around once a month
8. Less than around once a month
9. Never but I have access
10. Never but I do not have access

Question DAYOF
INTERVIEWER - CODE DAY OF WEEK
Monday
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday

Question INCOME
Could you please give me the letter from this card for the group in which you would place your total household income per year from all sources, before tax and other deductions?

WEEKLY INCOME		ANNUAL INCOME	
	£		£
E.	Less than 86	E.	Up to 4,499
K.	87 - 124	K.	4,500 - 6,499
S.	125 - 144	S.	6,500 - 7,499
P.	145 - 182	P.	7,500 - 9,499
L.	183 - 221	L.	9,500 - 11,499
J.	222 - 259	J.	11,500 - 13,499
A.	260 – 298	A.	13,500 - 15,499
T.	299 - 336	T.	15,500 - 17,499
D.	337 - 480	D.	17,500 - 24,999
N.	481 - 576	N.	25,000 - 29,999
C.	577 - 769	C.	30,000 - 39,999
F.	770 – 961	F.	40,000 - 49,999
R.	962 - 1442	R.	50,000 - 74,999
H.	1443 - 1923	H.	75,000 - 99,999
M.	1924 or more	M.	100,000 or more

Don't know
Refused

Question ETHNICITY
Which group on this card do you consider you belong to? Please read out the letter.

A. White - English / Welsh / Scottish / Northern Irish / British
B. White - Irish
C. White - Gypsy or Irish Traveller
D. White - Any other White background
E. Mixed - White and Black Caribbean
F. Mixed - White and Black African
G. Mixed - White and Asian
H. Mixed - Any other Mixed / multiple ethnic background
I. Asian/Asian British - Indian
J. Asian/Asian British - Pakistani
K. Asian/Asian British - Bangladeshi
L. Asian/Asian British - Chinese
M. Asian/Asian British - Any other Asian background
N. Black - African
O. Black - Caribbean
P. Black - Any other Black / African / Caribbean background
Q. Arab
R. Any other ethnic group
Don't know
Refused

v) Topic guide (cognitive interviews)

Topic Guide

Cognitive interview (Part B)

Introduction to the cognitive interview

The researcher will introduce herself, the research, confidentiality and the structure briefly. She will also mention when payment will be received.

My name is Salma Patel and I am a doctoral researcher at the University of Warwick. Thank you very much for agreeing to take part.

The purpose of this cognitive interview is for you to talk to me whilst you are answering the questions I ask you, and I am interested in hearing your thought process that leads you to answer any of the questions. I will also probe you with further questions that are not on the questionnaire.

Probing on information section

The researcher will read out the brief information section, and will probe to see if the participant understood it correctly, in particular that the questionnaire refers to feedback on GPs only, and not other services provided by GP practices.

Main questionnaire

Each question will be read out, and the participant will be encouraged to think aloud whilst responding. Where questions have more than 6 scales, the scales will be placed on a piece of card that will be given to the participant as he or she attempts to answer the question.

The participant will be probed by the researcher at these specific questions:

1. A1 – When you answered this question, what did care from a GP mean to you?
2. A2 – Are you more familiar with the phrase 'GP Practice' or 'GP surgery'?
3. A4 – What does formal mean to you?
4. A5 – did you find it difficult to select three options? Did you find it difficult to rank 3? Did you think the question was difficult to answer?
5. B4 – what does feedback mean to you?
6. C1 a) – what does positive feedback about a positive experience mean to you? What does feedback about a negative experience mean to you?
7. D6 – what does a doctor rating website mean to you?
8. D8 – do you know what an app is? Do you know what a kiosk is?
9. E1 a) – what does public domain mean to you? How do you understand that question?
10. F1 a) – what does "real name" mean to you?
11. F3 a) – what does "GP by name" mean to you?
12. G1 – how do you understand the term "long term condition"?
13. G2 – how do you understand the term "health information"?

The researcher will also probe after other questions too, if there is a cause for concern, or if the participant looked confused or took quite long to answer a question.

Other themes or areas unrelated to the questionnaire may be discussed too if relevant.

Improvements

Participants will be asked how the questionnaire or the interview experience could be improved.

Other

Is there anything else which you have now remembered which may be relevant to any of these themes? Are there any other issues which you feel are important in relation to this topic?

Summary

Researcher will end the interview, and thank the participant.

We have come to the end of our interview for today. Thank you very much for taking part in this study.

vi) Invitation letter (cognitive interviews)

WMG
Innovative Solutions

[Date]

Dear [Name],

Research on public preference and motivation for using online patient feedback

We are undertaking an independent study exploring public preference and motivation for using online patient feedback. We have a designed a cross sectional questionnaire on this topic and would like to get your feedback on this questionnaire.

Your participation would involve setting aside around twenty to thirty minutes to take part in an interview at your place of convenience. The study has research governance approval from the Biomedical & Scientific Research Ethics Committee at the University of Warwick. The enclosed information sheet set out the study in more detail.

If you would be happy to participate in this study, please contact the Chief Investigator Salma Patel by telephone on 07796 141550 or by email at: salma.patel@warwick.ac.uk.

Thank you for your time and we look forward to hearing from you soon.

Yours sincerely,

Salma Patel, Dr Rebecca Cain, Professor Kevin Neailey and Professor Lucy Hooberman

The Queen's Anniversary Prizes 2009

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THE UNIVERSITY OF WARWICK

vii) Information sheet (cognitive interviews)

Information Sheet for Participants

Cognitive Interview: public preference and motivation for using online patient feedback

You are invited to participate in this research. Before you decide whether or not to participate it is important for you to understand why the research is being done and what participating will involve. Please take your time to read the following information carefully and ask if anything is unclear.

What is the purpose of this interview?

This interview is the second part of a research study that aims to explore public preference and motivation for using online patient feedback to give feedback to general practitioners. Online patient feedback can be defined as feedback left by patients, carers or service users on public web-based platforms such as NHS Choices, Patient Opinion and iwantgreatcare.org; and on applications such as the iPhone based *Great Care* app.

The interview is based around a questionnaire that the researcher has designed, and you will be asked questions and asked to talk to the researcher whilst filling it in.

Do I have to take part?

No. It is up to you to decide whether or not to participate and you are free to stop your involvement at any time without giving a reason. Your decision will not impact in any way on your legal or employment rights.

What would be involved?

After you have agreed to participate, the researcher will arrange a time and place for the interview that is most convenient for you.

At the interview, you will be given the opportunity to ask any questions regarding the interview, and you will be asked to complete a consent form prior to the interview starting.

The interview will take between twenty to thirty minutes, depending on the depth of the discussions.

The discussion between you and the researcher in the interview will be audio recorded for transcription and analysis.

Will my information be kept confidential?

The information you provide to us will be kept confidential, and personal data will be anonymised at transcription. Only members of the research team will have access to your responses. Audio files will be transcribed without making a note of your name. Under no circumstances would identifiable responses be provided to the NHS or any third parties. All data collected will be destroyed at the end of ten years.

All data collection, storage and processing will comply with the principles of the Data Protection Act 1998 and the EU Data Protection Directive 95/46/EC.

What happens at the end of the study?

Study results may be submitted for publication in academic and professional journals, conference proceedings, books, online publications, and used for presentations at conferences and workshops. It will also be included in the doctoral thesis of Salma Patel.

Who is funding and conducting the research?

The research is being conducted by Salma Patel, a doctoral researcher at the University of Warwick.

It is funded by the Engineering and Physical Sciences Research Council (EPSRC) and is part of the Participation in Healthcare Environment Engineering (PHEE) programme. Further information can be found here: http://tinyurl.com/pheeproject

Who has reviewed the research?

The research has been reviewed and given a favourable opinion by the Biomedical & Scientific Research Ethics Committee at the University of Warwick as well as the NHS Cambridgeshire.

If I wish to discuss the study further who should I contact?

Please contact Salma Patel.

Email: salma.patel@warwick.ac.uk **Phone:** 07796 141550

University Address: International Digital Laboratory, WMG, University of Warwick, Coventry, CV4 7AL.

Who would I contact to complain about this research?

If you are not happy with the way in which this research has been conducted, you should contact the University of Warwick's Deputy Registrar, Nicola Owen (details below)

Email: DeputyRegistrar@warwick.ac.uk **Phone:** 02476 523713

Address: University of Warwick, Gibbet Hill, Coventry, CV4 7AL.

viii) Invitation letter (piloting)

[Date]

Dear [Name],

Research on public preference and motivation for using online patient feedback

We are undertaking an independent study exploring public preference and motivation for using online patient feedback. We have a designed a cross sectional questionnaire on this topic and would like to get your feedback on this questionnaire.

Your participation would involve setting aside around ten to fifteen minutes to take part in an interview at your place of convenience. The study has research governance approval from the Biomedical & Scientific Research Ethics Committee at the University of Warwick. The enclosed information sheet set out the study in more detail.

If you would be happy to participate in this study, please contact the Chief Investigator Salma Patel by telephone on 07796 141550 or by email at: salma.patel@warwick.ac.uk.

Thank you for your time and we look forward to hearing from you soon.

Yours sincerely,

Salma Patel, Dr Rebecca Cain, Professor Kevin Neailey and Professor Lucy Hooberman

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ix) Information sheet (piloting)

Information Sheet for Participants

Pilot Questionnaire: Public preference and motivation for using online patient feedback

You are invited to participate in this research. Before you decide whether or not to participate it is important for you to understand why the research is being done and what participating will involve. Please take your time to read the following information carefully and ask if anything is unclear.

What is the purpose of this questionnaire?

This pilot questionnaire is the third part of a research study that aims to explore public preference and motivation for using online patient feedback to give feedback to general practitioners. Online patient feedback can be defined as feedback left by patients, carers or service users on public web-based platforms such as NHS Choices, Patient Opinion and iwantgreatcare.org; and on applications such as the iPhone based *Great Care* app.

Do I have to take part?

No. It is up to you to decide whether or not to participate and you are free to stop your involvement at any time without giving a reason. Your decision will not impact in any way on your legal or employment rights.

What would be involved?

Participation would involve completing a questionnaire in the researcher's presence. It will take you no longer than 15 minutes to complete.

Will my information be kept confidential?

The information you provide to us will be kept confidential. Only members of the research team will have access to your responses. The responses will be coded without making a note of your name. Under no circumstances would identifiable responses be provided to the NHS or any third parties. All data collected will be destroyed at the end of ten years.

All data collection, storage and processing will comply with the principles of the Data Protection Act 1998 and the EU Data Protection Directive 95/46/EC.

What happens at the end of the study?

Study results may be submitted for publication in academic and professional journals, conference proceedings, books, online publications, and used for presentations at conferences and workshops. It will also be included in the doctoral thesis of Salma Patel.

Who is funding and conducting the research?

The research is being conducted by Salma Patel, a doctoral researcher at the University of Warwick.

It is funded by the Engineering and Physical Sciences Research Council (EPSRC) and is part of the Participation in Healthcare Environment Engineering (PHEE) programme. Further information can be found here: http://tinyurl.com/pheeproject

Who has reviewed the research?

The research has been reviewed and given a favourable opinion by the Biomedical & Scientific Research Ethics Committee at the University of Warwick.

If I wish to discuss the study further who should I contact?

Please contact Salma Patel.

Email: salma.patel@warwick.ac.uk **Phone:** 07796 141550

University Address: International Digital Laboratory, WMG, University of Warwick, Coventry, CV4 7AL.

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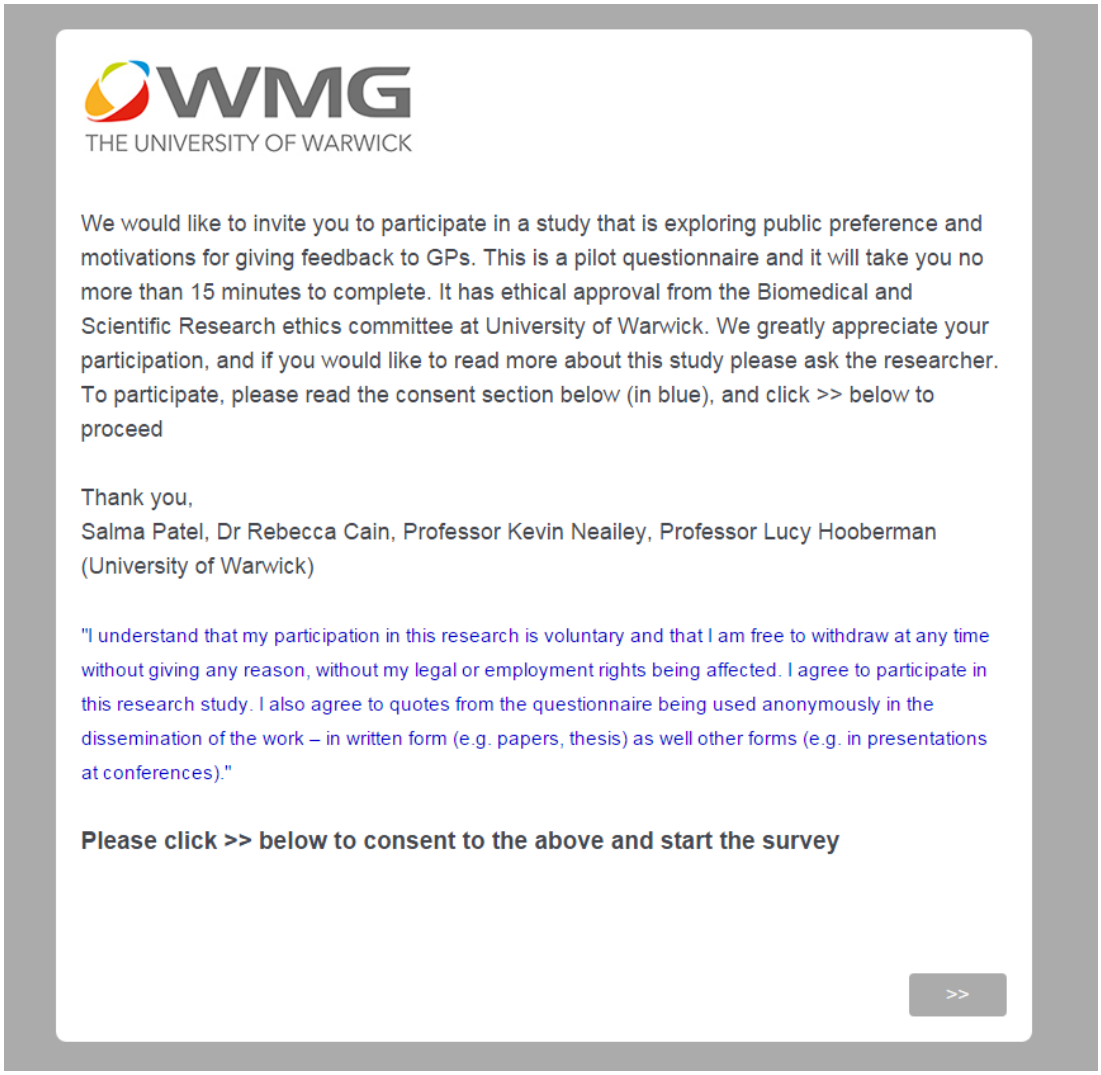
Email: DeputyRegistrar@warwick.ac.uk **Phone:** 02476 523713

Address: University of Warwick, Gibbet Hill, Coventry, CV4 7AL.

x) Web-based consent form (piloting)

The following consent form used was used to take consent from participants before the questionnaire was piloted.

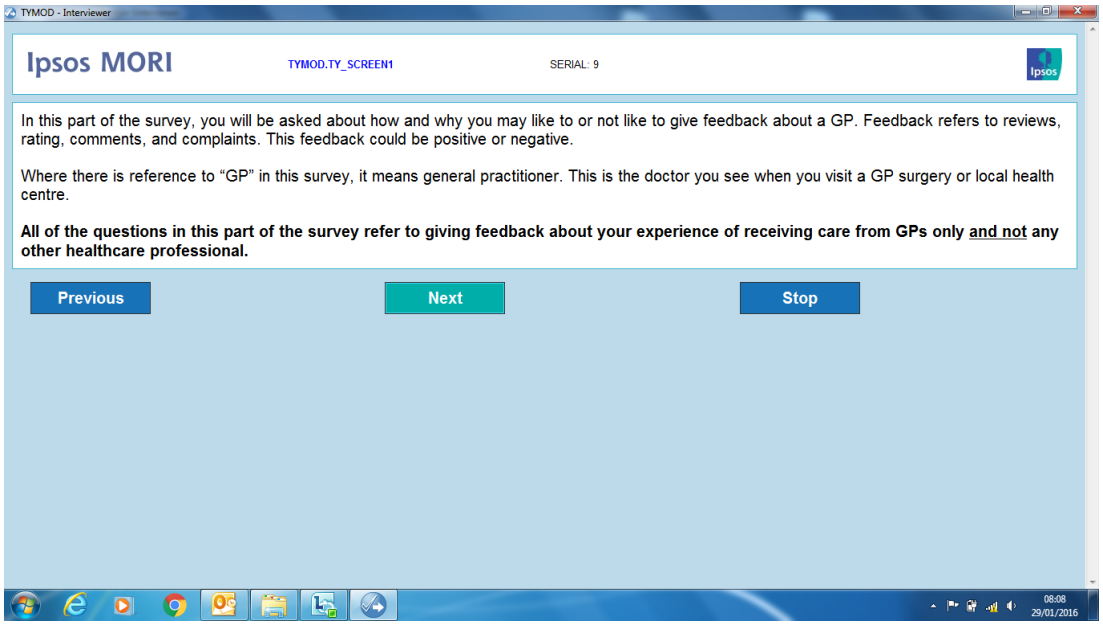


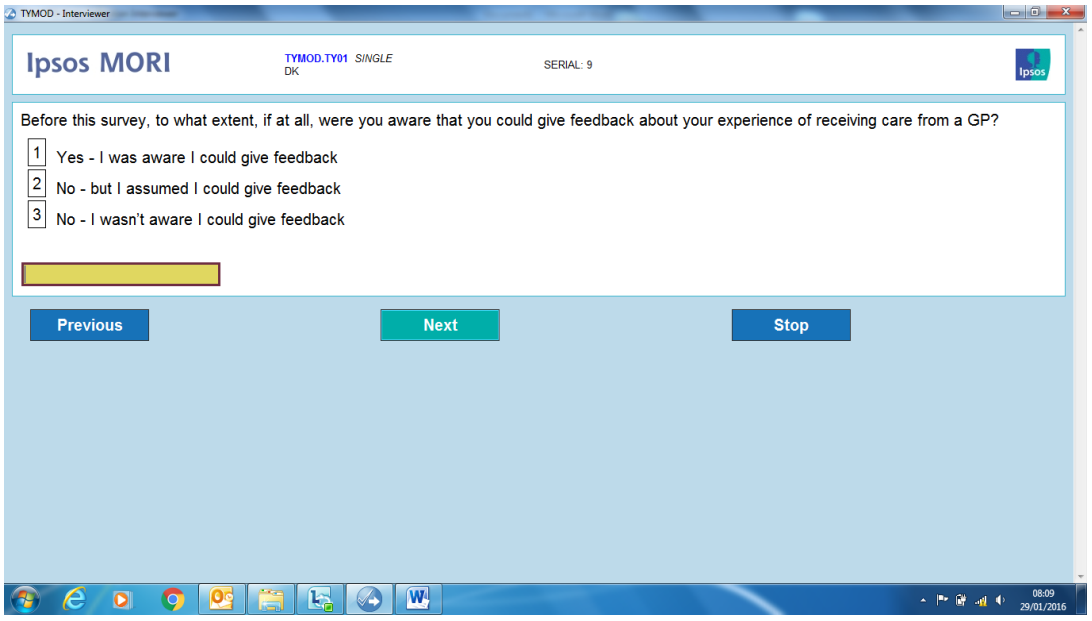
APPENDIX F – ADDITIONAL MATERIAL FOR STUDY C (PHASE 4)

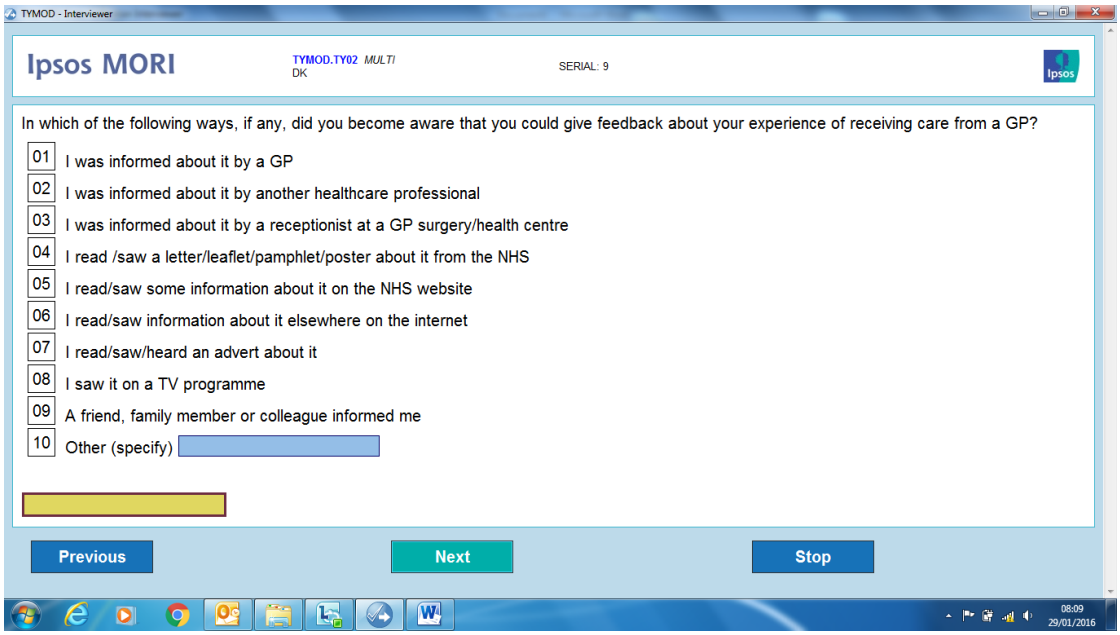
This section contains additional material related to Study C. This includes: i) sample of the questionnaire as shown to participants, ii) information sheet, iii) Showcard for question TY15 of the questionnaire, iv) weights used for Study C, v) additional demographics, vi) additional material for TY08, vii) supporting material for TY09A & TY09B, and viii) supporting material for TY19.

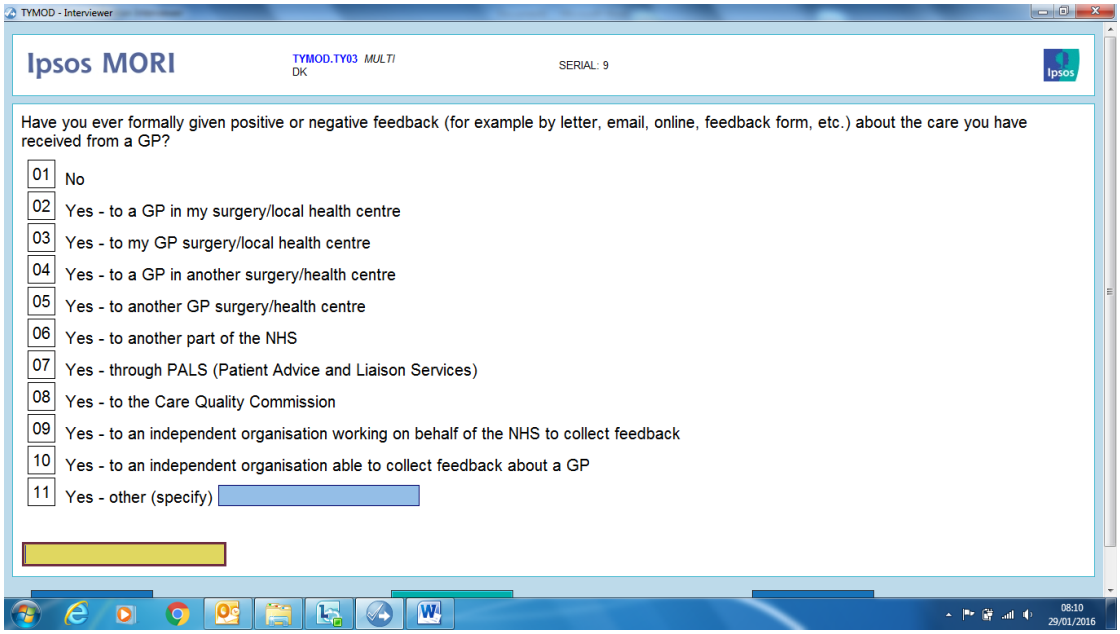
i) Sample of questionnaire as shown to participants

Four screenshots that were at the beginning of questionnaire as shown on the interviewers' laptops and to respondents are displayed below.






TYMOD - Interviewer
Ipsos MORI
TYMOD.TY02 MULTI
DK
SERIAL: 9
In which of the following ways, if any, did you become aware that you could give feedback about your experience of receiving care from a GP?
01 I was informed about it by a GP
02 I was informed about it by another healthcare professional
03 I was informed about it by a receptionist at a GP surgery/health centre
04 I read /saw a letter/leaflet/pamphlet/poster about it from the NHS
05 I read/saw some information about it on the NHS website
06 I read/saw information about it elsewhere on the internet
07 I read/saw/heard an advert about it
08 I saw it on a TV programme
09 A friend, family member or colleague informed me
10 Other (specify)
Previous
Next
Stop
08:09
29/01/2016


TYMOD - Interviewer
Ipsos MORI
TYMOD.TY03 MULTI
DK
SERIAL: 9
Have you ever formally given positive or negative feedback (for example by letter, email, online, feedback form, etc.) about the care you have received from a GP?
01 No
02 Yes - to a GP in my surgery/local health centre
03 Yes - to my GP surgery/local health centre
04 Yes - to a GP in another surgery/health centre
05 Yes - to another GP surgery/health centre
06 Yes - to another part of the NHS
07 Yes - through PALS (Patient Advice and Liaison Services)
08 Yes - to the Care Quality Commission
09 Yes - to an independent organisation working on behalf of the NHS to collect feedback
10 Yes - to an independent organisation able to collect feedback about a GP
11 Yes - other (specify)
08:10
29/01/2016

ii) Information sheet (Study C)

Information Sheet for Participants

You are invited to participate in this research. Before you decide whether or not to participate it is important for you to understand why the research is being done and what participating will involve. Please take your time to read the following information carefully and ask if anything is unclear.

What is the purpose of this questionnaire?

This questionnaire is the fourth part of a research study that aims to explore public preference and motivation for giving feedback to general practitioners.

Why have I been invited?

You have been randomly selected from a list of people living in the UK.

Do I have to take part?

No. It is up to you to decide whether or not to participate and you are free to stop your involvement at any time without giving a reason. Your decision will not impact in any way on your legal or employment rights.

Will my information be kept confidential?

The information you provide to us will be kept confidential. Only members of the research team will have access to your responses. The responses will be coded without making a note of your name. Under no circumstances would identifiable responses be provided to the NHS or any third parties. All data collected will be destroyed at the end of three years.

All data collection, storage and processing will comply with the principles of the Data Protection Act 1998 and the EU Data Protection Directive 95/46/EC.

What happens at the end of the study?

Study results may be submitted for publication in academic and professional journals, conference proceedings, books, online publications, and used for presentations at conferences and workshops. It will also be included in the doctoral thesis of Salma Patel.

Who is funding and conducting the research?

The research is being conducted by IPSOS Mori, on behalf of Salma Patel, a doctoral researcher at the University of Warwick.

It is funded by the Engineering and Physical Sciences Research Council (EPSRC) and is part of the Participation in Healthcare Environment Engineering (PHEE) programme. Further information can be found here: http://tinyurl.com/pheeproject

Who has reviewed the research?

The research has been reviewed and given a favourable opinion by the Biomedical & Scientific Research Ethics Committee at the University of Warwick.

If I wish to discuss the study further who should I contact?

Please contact Salma Patel. **Email:** salma.patel@warwick.ac.uk **Phone:** 07796 141550 **University Address:** International Digital Laboratory, WMG, University of Warwick, Coventry, CV4 7AL.

Who would I contact to complain about this research?

If you are not happy with the way in which this research has been conducted, you should contact the University of Warwick's Deputy Registrar, Nicola Owen. **Email:** DeputyRegistrar@warwick.ac.uk **Phone:** 02476 523713 **Address:** University of Warwick, Gibbet Hill, Coventry, CV4 7AL.

iii) Showcard for question TY15 of the questionnaire

J15-063333-04 **SHOWCARD TY15**

Good experience

1. I wanted to let the GP know how I much appreciated the consultation
2. I wanted to let the GP know that I appreciated the quality of their service in general
3. The reception or admin staff were really helpful
4. It was easy to get an appointment
5. The service was much better than what I'm used to/have experienced in the past

Sharing the experience

6. I believe sharing my experience would benefit the GP
7. I wanted to share my experience with other people
8. I thought other people could benefit from knowing about my experience
9. I wanted to ask other people's advice about my experience
10. I believe sharing my experience would make me feel better
11. I wanted to know if other people's experiences with the GP were the same as mine
12. I wanted to alert people to the mistakes or failings of the GP

Specific issue

13. I wanted to comment on my treatment or the service in general
14. I wanted to comment on a specific consultation

To get a response

15. I wanted to prompt the local health authority to respond to a complaint I had
16. I wanted to improve the service received from the GP

So it would be taken seriously

17. I believed the GP would take my experience more seriously if I shared it online
18. I believed the GP Surgery/local health centre would take my experience more seriously if I shared it online

Negative experience

19. I didn't like the attitude of the GP
20. I didn't like the attitude of the General Practice Nurse I saw
21. I didn't like the attitude of the reception or admin staff
22. I couldn't get an appointment
23. I couldn't see a doctor during the appointment
24. I have problems using the surgery's systems

Other

25. Other please specify

iv) Weights used for Study C

The weights used by Ipsos MORI to make the survey demographic profile in-line with the National Readership Survey and Census Data are given in the table below (as provided by Ipsos MORI).

Order of weighting	Variable	Total	Male	Female
Three	Government Office Region			
	North West		6.44%	6.75%
	North East		2.37%	2.51%
	Yorks & Humberside		4.86%	5.07%
	West Midlands		5.11%	5.31%
	East Midlands		4.22%	4.40%
	South East		7.93%	8.34%
	East of England		5.41%	5.68%
	South West		4.95%	5.20%
	Greater London		7.61%	7.85%
One	Social Grade of CIE			
	AB		13.98%	13.41%
	C1		12.35%	14.75%
	C2		11.76%	9.91%
	D		7.25%	8.05%
	E		3.56%	4.99%
Two	Age of respondent			
	15-24		8.06%	7.60%
	25-34		8.42%	8.38%
	35-44		7.82%	8.05%
	45-54		8.43%	8.68%
	55-64		6.67%	6.83%
	65+		9.49%	11.57%
Four	Working status of respondent			
	Working		29.83%	25.20%
	Not working		19.07%	25.90%
Five	Tenure			
	Owned Mortgage	32.99%		
	Owned Outright	31.00%		
	Rent LA	14.17%		
	Rent Private	21.84%		
Six	Ethnicity			
	White	85.98%		
	BME	14.02%		

v) Additional demographics

The following table shows the additional demographic characteristics of the sample (n=844) collected by Ipsos Mori but were not used in the analysis (including weighted and non-weighted frequencies):

Demographic characteristic	Unweighted Base	Weighted Base
TOTAL	***844***	***844***
CHILDREN IN HOUSEHOLD		
YES	243	261
NO	601	583
CHILDREN IN HOUSEHOLD		
AGED 0-5	135	143
AGED 6-9	83	93
AGED 10-15	109	118
NONE < 16	601	583
MARITAL STATUS		
MAR/ LIVING AS	487	506
SINGLE	233	221
WID/ DIV/ SEP	121	114
WORKING STATUS		
FULL TIME	323	370
PART TIME	86	95
NOT WORKING	435	379
DURABLES OWNED		
TV	815	813
SAT TV	401	421
FREEVIEW	448	439
MOBILE PHONE	782	790
TELEPHONE	652	655
PVR	286	288
CAR	649	664
PERS COMPUTER	315	325
LAPTOP	603	614
TABLET PC	470	492
GAMES CONSOLE	270	297
DVD PLAYER	490	496
CREDIT / DEBIT CARDS		
CREDIT CARDS	412	433
DEBIT CARDS	788	794
TENURE		
MORTGAGE/ OWNED	507	528
RENTED	326	304
OTHER	4	6
CIE WORK STATUS		

Demographic characteristic	Unweighted Base	Weighted Base
PAID JOB FULLTIME (30+HRS / WEEK)	412	457
PAID JOB PARTTIME (8-29HRS /WEEK)	47	50
PAID JOB PARTTIME (<8HRS / WEEK)	9	10
NOT WORKING HOUSEWIFE/ HOUSEHUSBAND	12	10
SELFEMPLOYED	43	45
FULL TIME STUDENT	39	29
STILL AT SCHOOL	1	1
UNEMPLOYED & SEEKING WORK	23	19
RETIRED	216	188
NOT IN PAID WORK OTHER REASON	18	14
NOT IN PAID WORK LONG TERM ILLNESS OR DISABILITY	23	19

vi) Additional material for TY08

The following table shows the complete set of results for participant's preference of which method to use to leave feedback about their experience of receiving care from a GP (TY08):

TY08 Summary: In which, of the following ways, if any, would you prefer to give feedback about a GP?				
Base: All Adults 15+ in England who would consider giving feedback about a GP				
	Positive		**Negative**	
	Feedback (Top 3)	**Preferred way**	**Feedback (Top 3)**	**Preferred way**
Unweighted Base	777	777	777	777
Weighted Base	776	776	776	776
Give feedback directly to the GP (either in person or by Telephone)	360	240	292	184
	46%	*31%*	*38%*	*24%*
Write a letter directly to the GP	179	63	186	77
	23%	*8%*	*24%*	*10%*
Send an email directly to the GP	217	94	196	87
	28%	*12%*	*25%*	*11%*
Give feedback to your GP surgery/ local health centre manager (either in person or by Telephone)	103	36	131	52
	13%	*5%*	*17%*	*7%*
Write a letter to your GP surgery/ local health centre's manager	59	17	89	35
	8%	*2%*	*12%*	*5%*
Send an email to your GP surgery/ local health centre's manager	79	31	118	35
	10%	*4%*	*15%*	*5%*

Fill in a feedback form at your GP surgery/local health centre (this could be anonymous or not)	178	72	181	79
	23%	*9%*	*23%*	*10%*
Fill in a feedback form on the GP surgery/local health centre's website (this could be anonymous or not)	103	43	132	51
	13%	*6%*	*17%*	*7%*
Post feedback on an NHS website that publishes feedback for GPs (and everyone can then read the feedback) (this could be anonymous or not)	64	24	67	26
	8%	*3%*	*9%*	*3%*
Post feedback on an independent website that publishes feedback for GPs (and everyone can then read the feedback) (this could be anonymous or not)	31	10	34	10
	4%	*1%*	*4%*	*1%*
Give feedback through an app on your smartphone directly to the GP surgery/local health centre (this could be anonymous or not)	34	17	49	23
	4%	*2%*	*6%*	*3%*
Give feedback through an app on your smartphone, which is then published to an NHS/Independent website (this could be anonymous or not)	*35*	*12*	*33*	*9*
	5%	*1%*	*4%*	*1%*
Give feedback through PALS (Patient Advice and Liaison Services)	*25*	*5*	*30*	*4*
	3%	*1%*	*4%*	*1%*
Contact the Care Quality Commission	*12*	*2*	*22*	*2*
	2%	*	*3%*	*
Give feedback on social media such as Facebook, Twitter, etc.	*19*	*6*	*26*	*5*
	3%	*1%*	*3%*	*1%*
Online	*1*	*1*	*1*	*1*
	*	*	*	*
Fill in a questionnaire by post	*1*	*	*	*
	*	*	*	*
Speak to the receptionist	-	-	*1*	*1*
	-	-	*	*
Other	*2*	*1*	*1*	-
	*	*	*	-
I would not give feedback for a GP	*96*	*96*	*80*	*80*
	12%	*12%*	*10%*	*10%*
No answer	*1*	*1*	*4*	*5*
	*	*	*	*1%*
Don't know	*5*	*5*	*7*	*7*
	1%	*1%*	*1%*	*1%*

NET: FEEDBACK DIRECTLY TO GP	***533***	***397***	***486***	***348***
	69%	***51%***	***63%***	***45%***
NET: FEEDBACK TO GP SURGERY/LOCAL HEALTH CENTRE MANAGER	***219***	***84***	***296***	***123***
	28%	***11%***	***38%***	***16%***
NET: FILL IN FEEDBACK FORM	***246***	***115***	***279***	***130***
	32%	***15%***	***36%***	***17%***
NET: POST FEEDBACK ON A WEBSITE	***89***	***33***	***90***	***36***
	12%	***4%***	***12%***	***5%***
NET: FEEDBACK VIA AN APP	***58***	***29***	***70***	***33***
	7%	***4%***	***9%***	***4%***

vii) Supporting material for TY09A & TY09B: Themes and codes illustrating the reason/s why participants preferred one method to give feedback to a GP over others																		
Ease and convenience		**A direct method**		**A less direct method**		**Leads to GP improvement**		**Anonymity**		**Helps other patients**		**Ensures feedback reaches the right person**		**GP/Practice can respond**		**Can give better quality of feedback**		**Official/formal channel**	
Pos	**Neg**	**Pos**	**Neg**	**Pos**	**Neg**	**Pos**	**Neg**	**Pos**	**Neg**	**Pos**	**Neg**	**Pos**	**Neg**	**Pos**	**Neg**	**Pos**	**Neg**	**Pos**	**Neg**
24% (n=198)	**28% (n=201)**	**16% (n=104)**	**14% (n=91)**	**1% (n=8)**	**6% (n=46)**	**3% (n=21)**	**3% (n=21)**	**1% (n=9)**	**3% (n=18)**	**1% (n=8)**	**1% (n=6)**	**4% (n=24)**	**6% (n=45)**	**-- (n=2)**	**2% (n=13)**	**1% (n=11)**	**2% (n=20)**	**1% (n=5)**	**2% (n=17)**
Easy / easier / simple		Direct / more direct		Prefer not to do it face-to-face / in person		To get some action / a resolution / an outcome		Anonymous / anonymity		Other people could see the feedback / it would reach more people		To ensure feedback is received / my views are noted / they listen		Gives people the opportunity / time to respond / answer criticism		Explain / express yourself better		Formal / professional / official	
15% (n=103)	18% (n=125)	6% (n=42)	7% (n=46)	-- (n=2)	2% (n=17)	1% (n=5)	1% (n=5)	1% (n=9)	3% (n=18)	1% (n=7)	1% (n=4)	1% (n=7)	2% (n=12)	-- (n=2)	2% (n=13)	1% (n=8)	1% (n=10)	1% (n=5)	2% (n=17)
Quick / quicker		Personal / more personal		Not confrontational / less aggressive / less threatening		To bring about change / get better service / improve				To help others / be helpful		It will reach the person / people concerned				Gives time to think about what to say / to give feedback			
6% (n=37)	4% (n=29)	4% (n=24)	2% (n=13)	-- (n=1)	2% (n=16)	1% (n=8)	1% (n=8)			-- (n=2)	--(n=2)	1% (n=5)	-- (n=3)			-- (n=3)	1% (n=10)		
Convenience / convenient / handy		Prefer to speak / talk to them		Not direct		To let GP know / how things are going						It's in writing / on paper / written record / evidence							
6% (n=41)	4% (n=28)	2% (n=13)	1% (n=9)	-- (n=1)	1% (n=8)	1% (n=8)	1% (n=8)					2% (n=12)	4% (n=30)						
It can be done sooner / straight away / there and then		Honest / upfront		Less personal															
2% (n=12)	1% (n=9)	1% (n=7)	1% (n=4)	1% (n=4)	1% (n=5)														
Comfortable / confident		Clear / avoid misunderstanding																	
1% (n=4)	1% (n=7)	1% (n=5)	1%(n=6)																
It can be done in your own time		I have a good relationship / get on well with / trust my GP																	
--(n=1)	-- (n=3)	1% (n=8)	1%(n=6)																
		Confidential / private																	
		1% (n=5)	1%(n=7)																
Key: Pos = Positive feedback Neg=negative feedback || **Total reasons mentioned**: For positive feedback (n=674) and negative feedback (n=685) || **Don't know** mentioned by 12% of participants for both negative and positive feedback																			

viii) Supporting material for TY19

The following table shows the complete results of the content analysis of a total of 673 reasons why participants would not consider giving feedback to GPs on a doctor rating website (ref TY19/D9):

Main Theme	Sub-themes	No of times mentioned by participants	Percentage
Theme 1: Not interested in leaving feedback		**96**	**14%**
	Don't want to leave feedback	16	2%
	Not interested / can't be bothered	56	8%
	No time / too busy	24	4%
Theme 2: Prefer giving feedback direct to GP/using other methods		**87**	**13%**
	I prefer direct feedback with GP	34	5%
	I prefer to give face-to-face feedback	28	4%
	I prefer other methods	16	2%
	Don't like anonymous feedback / too impersonal	9	1%
	I prefer to fill out a form	4	1%
Theme 3: No need to leave feedback		**80**	**12%**
	No need / not necessary / no reason to	49	7%
	Doctors should be the same standard	9	1%
	I would only do it if it was very serious / I was very dissatisfied	4	1%
	Only if I needed to	3	*
	No problems / happy with them	15	2%
Theme 4: Internet/website not accessible		**66**	**10%**
	Don't use the internet / websites	18	3%
	No internet access	16	2%
	Don't know how to use a computer / internet	16	2%
	Don't have a PC / computer / laptop	11	2%
	Too complicated / a hassle	5	1%
Theme 5: Online ratings are biased		**24**	**4%**
	People rarely leave positive feedback / most feedback is negative	8	1%
	Ratings are subjective / judged on different factors	6	1%
	Ratings might not be fair / accurate / reliable	10	2%
Theme 6: Privacy & security concerns		**20**	**3%**
	Too personal / don't want to give / share personal information	6	1%
	Don't trust them	14	2%
Theme 7: Dislike the website or not appropriate		**12**	**2%**
	Don't feel it is appropriate	4	1%
	Don't like them / don't agree with them	8	1%
Theme 8: Leaving feedback will not make a difference		**11**	**2%**
Theme 9: Website open to abuse		**8**	**1%**
	People can have a hidden agenda / an axe to grind	5	1%

Main Theme	Sub-themes	No of times mentioned by participants	Percentage
	Open to abuse	3	*
Theme 10: Do not see GPs frequently		**6**	**1%**
Theme 11: Cannot see another GP		**6**	**1%**
Theme 12: If asked to use, I would		**6**	**1%**
Don't know		***188***	***28%***
	Don't know	*168*	*25%*
	Never thought about it	*7*	*1%*
	No reason given	*13*	*2%*
Other		***101***	***15%***
	Other	*70*	*10%*
	I would use it for ratings / to find out ratings	*3*	*
	Didn't know about the site	*16*	*2%*
	I do my own research / go by recommendation	*12*	*2%*